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EDITORIALS

THE CONSCIOUS NURSE

Something has happened to "district" nursing. It has grown to the proportions of an institution. Imperceptibly, before our very eyes almost, it has lengthened its skirts, put up its hair, and emerged an adult. A young adult, to be sure, a promising adolescent, but an adult none the less. It has emerged with a positive objective, with a mature outlook, and a new need. Our communities are beginning to demand that we in the field not only nurse the sick but teach the well. Our families no longer need us to do everything for them. They are eager and ready to learn to do for themselves. And so, we face a serious challenge. Are we, the present generation of "district" nurses, prepared to teach them what they want to know about health or must they wait for another generation and still another perhaps, before their need can be answered? Obviously, they must not wait. Just as obviously, we are not prepared. How, then, are we to meet their challenge?

There is only one answer. We must prepare ourselves to teach. *How* are we to do it? This is our problem. Our supervisors are not only allowing but expecting us to cope with it. All along the line there has been a shifting of responsibility onto the shoulders that should rightfully carry it. Our families are ready for us. Our supervisors are waiting for us. Dictatorial supervision is a thing of the past. Our supervisors have stepped back and no longer desire to control us. They stand ready to be called upon for guidance only. The whole profession is ready to move forward. Only we lag behind. Public health attention is focused sympathetically but critically upon us, the field nurses. We *must* take control. We *must* assume our mature responsibility if the entire profession is to advance.

Actually, the public health objective has grown. "District" nursing has shifted its emphasis from *"illth"* to health. It is no longer, therefore, enough for us to be good doers, efficient nurses. We must become good thinkers, effective teachers. Generally, ladies, we must become conscious. That sounds almost insulting, doesn't it? It seems to imply that, up to now, we have been unconscious. Well, haven't we? Therein lies our challenge.

We have been so unconscious that having had the need to teach in the field pointed out to us, we were not even aware that we had been answering it!

We *have* been teaching, but unconsciously. Look back to your work yesterday. Didn't you demonstrate? Didn't you discuss? Didn't you instruct and impart information? Of course you did. Was there any family you left that was not a little the wiser for your visit? We teach—but with such waste! Our families should be a lot the wiser for our visits. We use methods but we are not conscious of what they are. We arouse motives, we influence attitudes, and we don't know how. Our problem is to become aware of our methods if we are to use them most efficiently, and if we are to eliminate the great waste through trial and error. If we continue to use the trial and error method, as we probably must for a time, it must be consciously used for an ultimate evaluation of our success. Our problem is not to learn something new, but to discover what we are already doing and how we are doing it.

Ours has been a sleepy generation, passive, unaware. So far we have been concerned only with the development of our own capacities and abilities. We have been immaturely egocentric. I do not speak critically. That was as it should have been. It was part of our natural professional growth. As children, we needed control, external control. We needed to learn to do. Now, doing has become habitual. It no longer demands our attention; it should no longer command it. We are ready to take the next step forward. If we are to grow up the emphasis of our attention must be shifted from ourselves to the world about us. We must begin to think, not of how our profession affects us, but of how we affect our profession. From the last generation of "district" nurses we inherited an excellent technique of performance. Up to now we have been occupied only with its application. To the next group we must bequeath as good a technique of teaching. It is our duty. It is their inherent right. We can and we must do it.

So much for the immediate need.

We are confronted with a broader and more lasting challenge. It will not be long before public health nurses will come to the field prepared with a teaching background. It is inevitable. Learning to teach is for us and for the next group, perhaps, immediately urgent. But we face a broader responsibility. The response to it must be the answer not to a changed objective, not to an immediate need, but to a constantly changing objective, and to consequent various needs. It would be a simple matter, indeed, if, having had progress pointed out to us, a problem discovered for us, and a definite method of coping with it devised for us, to learn the new method. But that will not be sufficient, and it is not mature. It is not assuming our full responsibility. From now on, recognition of changes and needs must come from *us*, not from others. We must become permanently, predominantly, conscious.

Not so long ago, it was enough for a nurse to be conscientious. It was characteristic for her to approach her work emotionally, to do what she *felt* was right. That day is past. The new nurse must learn to depend upon psychology for guidance. Her approach must become intellectual. She must do what she *knows* is right. Consciousness must dovetail with conscientiousness. Only thus can she keep in line, right foot forward.

What I have said may arouse lively discussion, possibly definite disagreement. I hope it does. Retaliation is a voluntary response, and that is evidence of consciousness!

G. JOAN COLB, R.N.,
Brooklyn, N. Y.

National Health Challenges Today*

By JOSEPHINE ROCHE

Assistant Secretary of the Treasury, Washington, D. C.

LAST Thursday came the eagerly awaited security message from our President, and with it the bill outlining concrete proposals to help meet the human welfare goals which our people have long visioned and which his leadership gives us hope of actually attaining.

Security of livelihood, of homes, and against major hazards such as illness, these goals are but a restatement in modern terms of the object and purpose for which our country was founded and for which progressive spirited men and women have worked and fought through all our history.

Waste, however, rather than conservation of our human and economic resources has been the force which has dominated our society in recent years. Today we are confronted by a double challenge; our national losses and breakdown, resulting from the growing inequalities and insecurity of the past decade, have thrust themselves upon the attention of even the most indifferent and will not be longer denied. We are challenged first to face these facts fully, to realize what we have permitted to develop in our democracy. This challenge, it would seem, has been met. It is difficult to believe that there are any who do not know the toll which has been taken in human suffering, in mental and physical disability, in community retardation. Yet it is a common human trait to escape from the unpleasant and to forget dark and tragic conditions at the first faint signs of encouragement. We must, therefore, sternly hold ourselves and others to a continuing recognition of the widespread and disastrous consequences of economic insecurity, even as we take up the second, more pleasant but equally exacting challenge to constructive action through ways now opening to us. And this action must bring both recovery and reform; meet immediate needs and lay the ground for long-time, ever-growing social progress.

As we eagerly start toward new trails being blazed toward our goal of human security, we naturally look for the one marked "Work Program" or "Home Building" or "Public Health" or "Child Welfare," according to the particular field in which we have in the past functioned. One of the lessons we have all learned, or should have learned, out of our coming to grips with unprecedented human denials and suffering these recent years, is how completely interwoven and interdependent our various responsibilities in changing the old order are. We've long talked about our age of specialization—the field of education, of industry; the field of child welfare, of health—and now we realize that our various fields are but small lots, separated from each other only by imaginary lines, in one great general field where we must do joint battle for our common cause, security for all human beings. Under our President's masterly conception of a related program we can go forward together, public and private forces, pooling our special interests and knowledge and drawing strength for each part of our program from each other.

No one, perhaps, so accurately visualizes the interdependence of the various phases of our security program as you of the public health movement who are here today, in person, and you who are equally here in spirit over the radio. Others of us have faced the extent and the threat of mounting unemployment, of foreclosed farms and homes, of closed factories, mines and workshops. But

*Presented January 21, 1935, at the luncheon of the National Organization for Public Health Nursing, New York City. The address was broadcast by the National Broadcasting System.

you who as nurses, public health officers, directors and members of vitally important private organizations for public health, have seen these mass statistics translated in terms of individual suffering, permanent physical and mental breakdown, and even death—you can tell as no one else the black story of the depression in terms of undernourished, sickly children deprived of all that it is a child's right to have; in terms of fathers and mothers crushed under the unbearable strain of insecurity and want. No report, I venture to say, is ever read by you giving mass data as to increasing death rates and sickness rates among these groups of citizens most seriously affected by the depression, that you do not instantly see before you the dreary families whose health you can do but little to safeguard against the odds of stark poverty.

The public health group is justified in having a special sense of the needlessness of much of our human waste because facts in the health field show what extraordinary results can be achieved in conserving human health and life. The achievements of research, the discoveries of medical science and their application to the prevention and treatment of diseases, are perhaps our most dramatic and valued developments of modern times. There has been a decline in our general death rate, our span of life has increased, and the toll taken by preventable disease has been decreased. The frightful scourges which swept away large groups of our population at intervals in past years are, we are told, substantially conquered.

Since 1900 the death rate from tuberculosis has been reduced by 60 per cent. But leading experts tell us that with adequate health facilities throughout the country it would be halved again. So, too, with infant mortality. The death rate of babies has been cut in half in the last quarter century, but it could be cut in half again, authorities tell us, if the known means of care and prevention could be made more widely available. Yet in 1933 twenty-five states showed no decline in infant mortality.

In progressive communities, since the introduction of modern public health procedure, one-third of the burden of preventable illness and premature death has been lifted from men, women, and children. But in only 528 out of our 3,000 counties are there full-time health services. Local appropriations for public health have been decreased by twenty per cent on the average since 1930. The per capita expenditure from tax funds for public health in 77 cities in 1934 was 58 cents as contrasted with 71 cents in 1931.

The general death rate showed a slight decrease at the end of 1933, but this is not the whole picture. Let's break down some death rate figures. Recent surveys by the United States Public Health Service and the Milbank Memorial Fund, in ten industrial localities, show that during the period 1929-1932 the death rate in families with no employed members or part-time wage earners increased twenty per cent, while in those families which had full-time wage earners it declined. Data for 1934 are not yet complete, but for the first half of 1934 the gross mortality rate in cities of 100,000 population and over is reported to be appreciably higher than in the same period of 1933.

The survey of the ten localities just referred to showed that the families which had suffered the most severe decline in income during the period 1929-1932 had a disabling sickness rate over fifty per cent higher than those whose economic status was not materially reduced. Experts tell us that the annual wage loss due to illness in families with $2,500 a year income or less is approximately $900,000,000—almost one billion dollars taken away from purchasing power, so desperately needing to be increased, not further lessened. The annual cost of care of four diseases, the morbidity from which we know how to control, is estimated at $115,000,000.

Obviously these facts reveal not only conditions of human suffering and wretchedness, but economic waste. Taxpayers' money, in the end, will be conserved by careful expenditures for prevention of disabling illness and the dependency which so often accompanies it.

As we resolutely face our second challenge, action to meet these conditions, we can do so fortified by knowledge of sure methods of progress, and by the equally heartening thought that we will go forward with our efforts, public and private, united. The long battle to gain more adequate recognition of the public responsibility involved in the nation's health seems to be gaining ground. In submitting the American Plan to Congress, our President said:

"We pay now for the dreadful consequence of economic insecurity and dearly. This plan presents a more equitable and infinitely less expensive means of meeting these costs. We cannot afford to neglect the plain duty before us. I strongly recommend action to attain the objectives sought in this report."

The bill accompanying his message provides, as you know, a ten million dollar appropriation for public health. Those sections read:

"There is hereby appropriated, from funds in the Treasury not otherwise appropriated, the sum of $10,000,000 for the fiscal year ending June 30, 1936, and there is hereby authorized to be appropriated for each fiscal year thereafter the sum of $10,000,000 to be allocated to the Bureau of Public Health Service to be expended as hereinafter provided. . . .

"From the amounts appropriated under this title, the Bureau of the Public Health Service shall annually allot $8,000,000 to the several states, in amounts determined on the basis of the need of each state for such assistance, for the purpose of developing state health services including the training of personnel for state and local health work and for the purpose of assisting counties and/or other political subdivision of the states in maintaining adequate public health programs. Payment of any allotment, or installment thereof, shall be made only after the Secretary of the Treasury has made a finding of fact that there is need to make such money available in such state. . . .

"From the amounts appropriated under this title, $2,000,000 shall annually be available to the Bureau of the Public Health Service, for the further investigation of disease and problems on sanitation, and related matters."

Such action is surely a challenge to all citizens, individually and collectively, to increase private efforts and activity, in order that the maximum progress in building for health may take place. There will be no more important rôle in this coming program than that of the public health nurse, whether employed by public or private agencies. We may well say, "May her tribe increase!" Concerned with individuals and families in sickness and in health, she serves them in their homes, in health centers, in schools and in industry. As a health teacher, scientifically prepared, with an influence and opportunity in the community held by few, she can arouse community interest for constructive and intelligent action to promote health and prevent disease.

Dr. Winslow will tell what is being done by this splendid group of citizens, our public health nurses, as visiting nurses, Department of Health nurses, school nurses, industrial nurses, Red Cross nurses, and you should be listening to his story rather than mine, over the radio.*

Their services in these recent dark years cannot be over-valued. Governor Lehman of New York has fittingly said:

"To them, I believe, more than to any other force in our discouraged world belongs the credit for upholding standards of health service. They have been unflinching in their courageous attack upon disease and suffering. They have been firm in the faith that somehow, some day, man's humanity to man might exceed his inhumanity."

Let us hope that their faith is soon to be justified as we move forward to our joint attack on the tasks ahead.

*See next page for Dr. Winslow's address.

National Health Challenges—How the Public Health Nurse is Meeting Them*

By C.-E. A. WINSLOW

Professor of Public Health, Yale School of Medicine

IT was just seventy-five years ago (in 1859) that William Rathbone of Liverpool—with the help of Florence Nightingale—established the first organized District Nursing Association to provide expert nursing care for the sick poor in their homes. In 1877 the earliest organization of this kind was formed in the United States by the Woman's Branch of the New York City Mission. In 1886 Boston organized its service under the significant title of The *Instructive* District Nursing Association. In 1893 two gallant young women, Lillian D. Wald and Mary Brewster, established themselves in the lower East Side of New York and climbed the rickety stairs of dark and gloomy tenements to bring relief to the suffering and to lay a foundation for the world-famous Nursing Service of Henry Street.

By 1900, however, there were still fewer than 130 visiting nurses in the United States. With the turn of the century progress was accelerated. By 1912 there were 3,000 visiting nurses. In that year two very important things happened. The National Organization for Public Health Nursing was founded; to stimulate and coördinate the whole movement on a national scale; and the American Red Cross initiated its rural nursing service. From one home to another in the village, from farm to farm in the isolated countryside, over the rough trails in the Appalachians and up the grim passes of the Rockies, the blue-clad or gray-clad nurses found their way, on foot or on horseback or in the trusty Ford. Their numbers grew—from 3,000 in 1912 to some 20,000 today. The considered estimate of the American Public Health Association assumes a need for 60,000 public health nurses to supply the minimum needs of the American people for fundamentally sound health service.

In England, the widespread development of the movement dates from the year 1887 when Queen Victoria allotted seventy thousand pounds of the Woman's Jubilee Offering, made as a personal tribute to Her Majesty, to the furtherance of district nursing; and in Sweden and other countries of northwestern Europe services of this kind were inaugurated at about the same time. On the whole, however, public health nursing of the modern type is essentially a product of the twentieth century. The foundation of the League of Red Cross Societies after the World War and the stimulus of the Rockefeller Foundation have played a major rôle in extending the movement to every quarter of the globe. The international course in public health nursing established by the League at Bedford College in London—in a single period of three years—had students from Austria, Belgium, Bulgaria, Canada, Czechoslovakia, Denmark, Esthonia, Finland, France, Great Britain, Greece, Hungary, Iceland, Italy, Japan, Mexico, New Zealand, Peru, Poland, Portugal, Roumania, Russia, Serbia, Siam, Sweden, Switzerland, the United States, and Venezuela. As I look back over my own personal memories I recall such pictures as the following.

The Department of the Aisne in France just after the war. Villages, merely heaps of tumbled ruins. The peasants who had come back from exile living in rough shacks made of boards or in dugouts improvised from old petrol drums, cautiously plowing their fields to avoid as far as possible the un-

*Presented at the N.O.P.H.N. luncheon held in New York City, January 21, 1935.

exploded shells which dotted them. The nurses of Anne Morgan's Committee for Devastated France quietly picking their way among the ruins to bring the first semblance of humanity and of organized community life to the desolate scene.

A village in the remote Carpathian Mountain regions of Czechoslovakia. A people who dwell in primitive log houses and dress in quaint Elizabethan dress and in every way live as their ancestors and ours lived three hundred years ago. The floors of the cabins of earth and the babies kept out of reach of domestic animals swung in a basket from the low-hung ceiling. In one of these snow-bound villages an infant welfare station and a public health nurse functioning in just the way she would be functioning in Westchester County of today—and receiving from the mothers of the Carpathian babies an intelligent and eager support that in this one respect bridged the gap of three centuries and brought them the hope and the courage of the modern scientific world.

The great sweeping plains of Macedonia. Peasant women of Slavonic stock in heavy linen smocks embroidered with beads working in long lines in the fields, each "hoeing her own row." Five miles away a Mohammedan village where the women—more conservative than their sisters in the new Turkey—go heavily veiled. Linking together the diverse races and creeds, a little rural health center with one room for shower baths and one for medical examination of school children—and the public health nurse plodding over the roads where the armies of Philip and Alexander marched, a messenger of love and service instead of a harbinger of war.

There must be good reasons for the spread of a new movement throughout the whole world in such a brief period of time. We may well ask ourselves the question, "What is a public health nurse and why is she so important?"

The term "public health nurse" according to the Manual of the National Organization for Public Health Nursing "applies to any graduate nurse who is taking part in an organized community service to individuals and families, including the interpretation of medical, sanitary, and social procedures for the correction of defects, prevention of disease and the promotion of health, and may include skilled care of the sick in their homes." She is distinguished on the one hand from the nurse who works inside a hospital or other institution and on the other hand from the nurse who cares for sickness in the home as the temporary but full-time employee of an individual patient. Like her sisters, the institutional nurse and the private-duty nurse, she works under the direction of the physician and is his invaluable aid in the relief of suffering and in the even more significant task of protecting and promoting health.

The visiting nurse of earlier days was chiefly concerned with bedside care (although Florence Nightingale herself thought of all nurses as essentially health teachers). The public health nurse employed by most official health departments is largely concerned with health teaching. Many of us believe that the most effective type of public health nurse is one who combines both functions. At the bedside, she plays an essential rôle in caring for persons who stand in need of skilled nursing but do not require continuous twenty-four hour or twelve-hour service; lacking the public health nurse, such patients would go without the care they need or the family or the community would be put to the unnecessary cost of hospitalization or of private duty nursing. On the educational side the value of the public health nurse is even more unique. The most essential factor in the modern health program is health teaching. To help the expectant mother to prepare herself for her hazardous task, to keep the baby well by instruction in the arts of feeding, airing, and clothing, to check the spread of major and minor contagious diseases by household and personal practices of sanitation, to secure protective immunization of children against smallpox and diphtheria, to adjust the family food budget to economic limitations and hygienic needs, to prevent and cure tuberculosis

by healthy living, to check the organic diseases of adult life by an appropriate regime—these are our chief objectives. They all depend on sympathetic training of the individual in the practice of health habits; and it is primarily to the public health nurse that we must look for such education. Furthermore, she is the most potent factor in bringing the individual who needs medical attention to the physician at a stage when his ministrations may prove most effectual. As has been said the public health nurse is "the enacting clause of all public health legislation." She is the vital link between the scientific laboratory and the home in which its discoveries must be applied. She is the "Minister of Healing and the Messenger of Health."

Dean Annie W. Goodrich in her address at the dedication of the new building of the Henry Street Nursing Service takes Dickens' description of the hurrying footsteps in "A Tale of Two Cities" as a symbol of the pervasive and permeating sweep of the nurse's work. "There was a great hurry in the streets. The wonderful corner for echoes resounded with the echoes of footsteps coming and going." "'Is it not impressive, Mr. Darnay?' asked Lucie. 'I have sometimes sat alone here of an evening, listening until I have made the echoes out to be the echoes of all the footsteps that are coming by and by into our lives.'" Can you not hear the footsteps of the thousands of nurses all over this country, passing through the streets approaching waiting doors, to bring their skill and knowledge to those who live within?

In a day one of these nurses may visit a critical case of pneumonia; she may bring comfort and relief to an old man suffering from incurable organic disease to whom the bath and the personal contact with her friendly sympathy is the one bright spot in the day; she will surely call on at least one young mother and talk over with her the baby's progress and help her in the arrangement of his daily regime; she will probably have at least one tuberculous family on her list and will arrange not only for the care of the patient but for bringing other possibly infected members of the family to the physician or clinic in order that the disease may be detected and checked in time; in almost every family she will find dietary problems, economic problems, problems of mental and emotional maladjustment which she must deal with herself or refer to the proper authorities for special care. The family is the unit with which she deals and it is her mission to bring about harmony between the family and its physical, social, and emotional environment by adjusting the family to that environment or by modifying the environment itself.

If you would visualize this mighty social phenomenon, you must look far beyond the limits of Manhattan Island and beyond the world bounded by city streets. You must hear the put-put of a motor boat which carries one nurse I know through the icy seas from one desolate island to another off the coast of Maine near Mt. Desert. And you must strain your ears for the creak of leather and the clink of hoof on stone as the nurses of the Frontier Nursing Service ride over the rough trails of the Kentucky mountains to bring the salvation of modern medicine to the rugged pioneers of the "Forgotten Frontier." In a series of two thousand deliveries they have lost only three mothers, under conditions of poverty and destitution which in similar regions of the Appalachians would have cost some twenty women's lives.

The work of the individual public health nurse is essentially a direct personal service, the focusing of technical skill and professional knowledge upon individual human need. The movement as a whole, however, has much wider social implications. In at least three respects it has contributed to our knowledge of the way in which a professional group may be organized for the public service.

First of all, it is significant that the public health nursing organization has shown how one form of nursing care can be provided for all the people in a community—at cost to those who can pay the full cost, for part pay to those

who can bear a part of the burden, and free to those who cannot pay at all. It is the glorious ideal of medicine that human need rather than capacity to pay shall always be the touchstone of service; but this ideal has been more fully realized with a more complete protection of the self-respect of the necessitous patient, in the field of public health nursing than is the case in any other area of medical care. The entire emphasis of modern public health nursing is upon the significance and the dignity and the human potentiality of the individual who is to be served.

In the second place, public health nursing has demonstrated in a striking fashion how the organization of a professional group for community service can be utilized as an instrument for building up and maintaining professional competence. The standards of selection, staff education, and supervision which are in force in the leading public health nursing services form a source of inspiration to the entire nursing profession and furnish a fruitful suggestion as to the values of group organization for service for allied professions as well.

Finally, the voluntary public health nursing association has taught us an important lesson as to the peculiar values of lay coöperation in the general field of community service. The directors of these organizations throughout the country have worked out the philosophy of the relationship between board and staff and have illuminated the general function of the executive and the volunteer in a way which has already aroused the keen interest of social service and hospital as well as nursing groups.

How has all this been accomplished? Basically, of course, through the vision and courage and leadership of the nurses and the board members who have built up the local services in city and town and village, from Maine to California, and from Florida to Oregon. It would, I think, be fair to say, however, that the major single factor which has made sound progress possible has been the central organization known as the National Organization for Public Health Nursing. This organization was established in 1912 with objectives which its constitution now states as follows:

"1. To stimulate responsibility for the health of the community by furthering the establishment and extension of public health nursing and the education of nurses in public health.

"2. To develop standards and technique in public health nursing.

"3. To facilitate efficient coöperation between nurses and health officials, physicians, boards of trustees, and other agencies and persons interested in public health.

"4. To establish and maintain a central bureau for information, reference, and assistance in matters pertaining to public health nursing.

"5. To publish periodicals and to issue bulletins from time to time to aid in the accomplishment of the general purpose of this Organization."

It is the National Organization for Public Health Nursing which has developed and set the admirable standards which govern the administration of our local services and the policies and techniques which they employ. Through the Joint Vocational Service, it provides public health nurses with jobs, and associations with qualified experts. Through its Biennial National Convention and through institutes and conferences held throughout the country it advances knowledge of the nursing aspects of tuberculosis and social hygiene and industrial hygiene and child health. Its monthly journal, PUBLIC HEALTH NURSING, is invaluable to every worker in public health. By field studies and surveys, by personal contacts in the central office at New York and in the home office of the local associations and by correspondence, its staff aid in the problems of developing the best service, promoting public understanding, providing sound office management and cost accounting, budgeting and record keeping. Its Board and Committee Members' Section is the center for discussion and development of the philosophy and methodology of lay coöperation. In fact this national organization is the heart and brain of the entire movement.

It is this movement as a whole, and the National Organization as its vital

nucleus, for which we bespeak your interest and understanding. It is a movement peculiarly of our own time and of our own country. It is instinct with the ideal of applying scientific knowledge for the individual good which is the underlying motive of the modern age. It is based on the conception of voluntary coöperation for the common welfare which is the essence of American democracy. When Reni-Mal, the official French painter whose posters familiarized a war-ridden world with the plight of the poilu, sought after the War to find an American type to stand as a personification of what he held to be this country's gift, he decided upon the public health nurse as the "Unique American."

The desire for immortality is a deep and basic human longing. We know but one sure and certain way of attaining it—by building something of ourselves into the structure and the fabric of human experience. The scientist, the artist, the builder who has wrought new knowledge into the warp and woof of thought, who has brought new beauty into the field of human experience, has won a real share of immortality. T. S. Eliot has recently written a moving drama called "The Rock" on the theme of church building. One of his humble workmen says, "You needn't believe in God but you've got to believe in a buildin'. It goes up and up in the sky, and on and on through the years, and it speaks with its lights and its bells in the night and in the sunshine—and it stands when you and I are dust, what built it for the glory of God—and that church 'as been put up with 'ands, buildin' buildin', buildin'—all through the years—in the rain and 'eat and 'ail and snow—workin' in bricks and mortar, goin' on forever and ever, buildin' the church of God."

Monuments to the glory of God are not built only of bricks and mortar. They may be built of human experience and human striving in any field of noble endeavor. A new program of social welfare, a new way of bringing human knowledge and human service to fruition for the welfare of mankind is a cathedral. And such a cathedral has been built by the pioneers in public health nursing. All through the years—in rain and heat and hail and snow, they have built it. It speaks with its lights of knowledge and its bell-notes of human compassion in the night and in the sunshine. It is not fixed and final like a cathedral of stone. It is a living cathedral whose building in very truth goes on forever and forever.

To help in that building in such ways as we can, is a privilege of which those of us who are not nurses may be proud.

WARNING TO KITE FLIERS

The kite-flying season is officially here and if this year's record runs true to form youthful America will pay with the lives of several youngsters for its fun. The age-old sport, relatively harmless in a former day, is now beset with two prominent hazards—high voltage electricity and traffic.

"A survey of numerous child accidents shows that there are several conditions to be considered if these accidents are to be stopped. The elimination of kite-flying in the vicinity of high voltage lines is imperative. . . The use of fine wire or cord with a wire woven into it should be abolished. So should kites with metal or wire frames. . . . The Council also warns that it is dangerous to fly kites in a thunder storm. The wet cord or wire may act as a conductor for electricity. . . Kite-flying adds one more hazard to the ever-present dangers of traffic. Children, in their attempts to elevate their kites, often run directly into the path of speeding automobiles. The pastime should be restricted to vacant lots—away from traffic and away from wires."

—National Safety Council, Chicago.

National Health Insurance in Great Britain

By IRENE H. CHARLEY, S.R.N.

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As a part of our New Year's resolution to supply our readers with information on health insurance, we are glad to offer this clear and comprehensive description of the British system as it concerns public health nurses.

THE National Health Insurance Act became law in 1911 and it can be truly said that no measure has ever passed through the British Parliament which directly affected the intimate daily life of so large a proportion of the population of the country. In fact the law required all sorts of duties from all sorts of people and perhaps the furore of opposition to the Act which arose in the early days was due to the multiplicity of trifling details which ordinary folk were expected to carry out. However, the years have passed and the scheme has become so much a part of the social structure in this country that it would be difficult to think of the time before such insurance facilities were available.

There is perhaps no more complicated piece of social machinery existent in any country as the scheme under review, but in this article it is not proposed to discuss the pros and cons of the details of administration, but rather to throw some light on the effects which are noticeable on different groups of the population.

USING EXISTING AGENCIES

In a truly British way every use was made of the existing social machinery to administer the Act and no special state department was set up.

For centuries there had been sick and benevolent societies which had helped their members who were in distress; these societies had developed from the ancient Guilds and were famous for the efforts they exerted to encourage their members to "put by" for a rainy day. In emergencies such as death, a levy would be made on the members and in many other ways the need of the moment would be met. It was the lack of uniformity in these provisions which made a change necessary but the genius of the scheme has been proved without question inasmuch as the existing machinery, spreading as it did into every village in the land, and covering every trade and industry, was called into use for the unification of the scheme.

These ancient Societies were to be termed "Approved Societies" and in order to be allowed to administer the Insurance Act certain definite standards were required and the transactions of the Society were open to the strictest scrutiny by the appropriate government department.

State insurance schemes vary in the provisions made from country to country but in Great Britain the statutory benefits are as follows:

(1) Sickness benefit
(2) Disablement benefit, which is an extension of sickness benefit after the right to that benefit has ceased
(3) Maternity benefit
(4) Medical benefit

The first three benefits are paid in money and are controlled by the Approved Societies. The medical benefit gives the right to the service of a "panel" doctor. The insured man or woman alone is entitled to this service—dependents are excluded from all benefits and in this respect the British scheme differs from several other continental plans.

The control of the medical benefit is

in the hands of a local Insurance Committee which was created for the purpose. The majority of members on these committees come from Approved Societies with medical representatives and the voice of the insured population is also heard.

The function of this Committee is to enter into agreements with doctors to serve on the "panel," to control the number of patients any one doctor may enrol, and the hundred and one other medical details which fall within its scope. The doctors are paid for their services by a per capita fee.

An argument which is often advanced against this decentralized arrangement is that the facilities which an insured person can obtain are still not uniform throughout the country. That is so. Many Approved Societies are organized according to trade—*e. g.*, the miners are often attracted to a special Society and the same is the case for domestics. The health hazards vary considerably in the same way, and so the surplus money will fluctuate according to a good or a bad claims year. Speaking generally, miners will claim heavily on their Society, whereas clerks may have a very different health experience. That means the clerks will have ample funds for the extension of benefits, but the miners will be debarred from making use of them because there is no money to provide them.

"Additional benefits" are offered at the discretion of the Approved Societies after periodic valuation of their funds and at the moment the most popular are the provision of convalescent home treatment and dental and optical benefits.

HOW NURSING COMES IN

Speaking before the passing of the Act, Mr. Lloyd George, who was Prime Minister when the Act became law, said: "Any system of doctoring is hopelessly insufficient unless it is supplemented by a good system of nursing." At that time it was hoped that a nursing service would also be provided through the Act, but no doubt due to the fact that popular opinion was not then ready to appreciate the value of the nurse as a cog in the great wheel of social insurance, this provision was not made in general. However, the most enlightened of the Approved Societies offer a limited home nursing service, an extension of which is much needed. The actual nursing care is given by the Queen's and other district nurses and the fee of approximately thirty cents is paid per visit. Such nursing care is available for the insured man or woman only and does not cover any other members of his family.

It is thought by many that the maternity benefit should be paid direct to the midwife in charge of the case and not to the parents so that the midwife is assured of her fee. Unfortunately, a new perambulator or shawl is often purchased with the money and the midwife's fee is left unpaid. In this respect a point of view which remains unshaken is that the insured person should receive as far as possible benefits in money and not in kind and the midwife's plea has, therefore, remained unheeded.

DO PEOPLE LIKE IT?

It may be interesting to nurse readers of this article to hear the actual replies which were given to a question—Do you approve of the National Health Insurance Act? This question was put to hundreds of working men and mothers during a survey which was made at the request of the Metropolitan Life Insurance Company of New York by an English nurse, who was employed for the purpose by the Central Bureau for Industrial Nursing, Ltd. The interrogator was a trained nurse who had the happy knack of reproducing the cockney vernacular as some of the following extracts will show.

(It should be explained that in popular speech the Insurance Act is known as "Lloyd George" or "the panel," and that "going on the panel" is just a way of saying that the patient is claiming insurance benefit.)

Here are some of the extracts:

"My husband likes the scheme but not Lloyd George. Don't you think a good deal depends on the patients? Some set out to

grumble at everything. My husband has never been on the panel. We have had a bad time of sickness this year, the doctor was ever so good."

"There was more anxiety for people before the National Health came in. Anything that makes you 'put by' is a good thing. There was something in the paper the other day about people abusing it and going on the panel for almost anything, but that should rest with the doctor. Some people don't like Societies paying different but I think the competition is good."

"I can speak nothing but good of the scheme. I have had a lot from it. I have been ill since 1921 with toxic goitre and now it has left me with a weak heart. I have drawn on the National Health all these years and now I am getting disablement benefit. My panel doctor, who is a lady, is very good. I was called before the insurance referee once. He was very kind and told me I must rest as much as possible."

"The chaps at our place don't seem to care about it. They seem to think there is a catch in it. Well, anyone knows insurance companies don't give anything for nothing. There are two doctors round here and you couldn't have better men. When I go and see mine he always examines my chest. I told him once I felt fit for work. He said, 'I will tell you when you are fit—take another week!' "

"I cannot get into any insurance because I have a bad heart. I have only been on the panel once but our doctor treats all his patients alike, he does. I had to have new teeth and got more than half the money through the panel. I should have got more only I lost a fully stamped card."

"I remember the days before 'Lloyd George.' You used to get sick pay then from the Poor Law or it depended on your employer or you had to 'put by' yourself."

"I think people are better off since 'Lloyd George' came. A man doesn't 'put by' for sickness, he doesn't think, you know, and it is wise to have something coming in. I reckon it does good as regards that and I think more children have come since then. They think of getting the money and forget the expense afterwards."

A shopkeeper thinks: "There's less poverty since it came in and the workhouses are not so full. It's certainly rather a nuisance stamping the cards, but I think it's worth it."

"It is good to be able to have the doctor when you want him. If you had to find the money each time you might not have him at all. Our doctor gave my husband something that was really too expensive and he got into trouble with the Ministry of Health—the doctor did. I mean properly hauled over the coals, he was."

"I reckon when 'Lloyd George' came in there were more children born than ever before and now we turn round and grumble at him because we haven't enough to keep them all. Then again, before 'Lloyd George,' if you were ill you had to go to the Relieving Officer."

The final analysis of the survey showed that very few were not in favor of the scheme, but there was evidence that changes in some directions were needed. There was a feeling that benefits and contributions should not be at a flat rate but should be assessed according to circumstances. There was a strong opinion that wives and dependents should be included in the scheme.

An almost unanimous vote was indicative, that the "panel" doctors were overworked and were unable to devote sufficient time to each patient. Several who at one time had been patients had an idea that only the cheaper and less efficient drugs were obtainable on the panel. However, knowing the psychology of the people visited, it is not surprising to find that in a great many instances they stressed the fact that all medicines should be available, the bottle of physic still being regarded as the most probable source of cure.

NURSING ANSWERS

Speaking in general from the nursing point of view, there is only one answer to the question—"Do you approve of the National Health Insurance Act?" It is that before the Act it was extremely difficult to get medical attention for a patient who was not covered by any club or benevolent scheme. Pride forbade that the nurse should in some cases call in the Poor Law doctor and as she was unable to continue to give nursing care without a doctor in attendance, it sometimes happened that treatment was not given and the closing of such an unimproved case meant much misgiving and dissatisfaction.

A comparison which is interesting and which has been obtained from comparable records which have been analysed by an insurance company on each side of the Atlantic and which are considered reliable because the same statistical standards are followed, show that .8 per cent in the English company are

un-nursed because the patient refuses for one reason or another to call in the doctor. In America the figure is 4 per cent for the same reason, and no doubt one of the causes of this disparity is that a doctor is more easily obtainable in England through the Insurance scheme.

A group of public health nurses who are indirectly connected with the Act are the Health Visitors, but as their duties are confined to the child under five years they are not brought into direct contact with the working of the scheme, except as they meet the other health problems in the home while visiting. Where they are working in a generalized nursing service and concerned with midwifery, tuberculosis and general district work, they would no doubt agree with the general point of view held by the nursing profession.

There are many extensions which the nursing world would like to see. A specialist service is needed, facilities for the newer treatments—especially balnological treatments for rheumatic diseases—would be welcomed and a wider use should be made of the power given by the Act to carry out health propaganda schemes. There is a clause in the Act which allows the expenditure of money for health teaching purposes but little use has been made as yet of the power which has been given.

In conclusion it should be said that any scheme which does not include as a fundamental benefit the provision of home nursing must be found wanting when weighed in the balance, for nursing service should be considered an integral part of any scheme for the alleviation of suffering and the prevention of disease.

If our readers have questions with regard to this article or with the subject in general, this magazine will be glad to receive them.—The Editors.

DR. GEORGE H. BIGELOW

Dr. George H. Bigelow, formerly State Commissioner of Public Health in Massachusetts, disappeared on the morning of December 3, 1934. It is possible he is a victim of amnesia and for that reason we are asked by the State authorities and at the earnest request of his family, to publish this description of Dr. Bigelow:

Six feet tall; weighs approximately 175 pounds; has deep blue eyes; heavy shock of black hair closely cut, slightly gray at the temples. He is of rangy build. When he left his home he wore a soft brown felt hat, a black overcoat with a velvet collar, a brown suit, and tan rubber-soled shoes, and a soft white shirt. He is 44 years of age. He wore a square silver wrist watch with a leather strap, and carried a brown pigskin brief case.

The finger prints of Dr. George H. Bigelow are in the possession of the Department of Public Safety of the Commonwealth of Massachusetts. Hospitals are requested to finger print all amnesia victims unidentified, forwarding them to Colonel Paul G. Kirk, Commissioner of Public Safety, State House, Boston, Mass.

Controlling Tuberculosis*

By H. E. KLEINSCHMIDT, M.D.
Director of Health Education, National Tuberculosis Association

BUBONIC plague threatens constantly, for nests of it continue to exist in various parts of the world. Yet bubonic plague gives us in the United States little concern. The reason we are practically free from this epidemic is because of the eternal vigilance of our public health agencies along the entire coastline, who see to it that flea-infested rats from bubonic ports do not enter our shores. Bubonic plague can thrive only through migration.

The tubercle bacillus, sole cause of tuberculosis, can perpetuate itself as a species only by migrating from one body to another. With the death of the victim of this disease millions of tubercle bacilli die, and are buried, with him. If somehow we could prevent the migration of tubercle bacilli from the sick to the well we should shortly starve this disease out.

Environmental factors do play an important part in the drama of tuberculosis; resistance-lowering influences do undoubtedly affect the tuberculosis death rate. But these are contributory causes. An infected child will develop tuberculosis *if* he lives in crowded quarters, *if* intercurrent illness cuts down his health resistance, *if* he is subjected to strain, and so on. We rightly concern ourselves with these if's and their remedies. But when emphasis on health camps, poster contests, toothbrush drills, butter-'n'eggs make us forget the big IF, namely, tubercle bacillus infection, we are neglecting the fundamental element of tuberculosis control. Inhibiting the migration of tubercle bacilli is the first essential of the tuberculosis program.

CONTROL MIGRATION OF BACILLI

Two varieties of opinion as to the significance of infection with bacillus tuberculosis are commonly expressed by epidemiologists. According to one group, a little tuberculosis is beneficial on the theory that it serves to tuberculize or "vaccinate" one against more serious reinfection. Some even go so far as to advocate the artificial vaccination (with BCG) of all infants. The other group opinion is to the effect that immunity acquired at the risk of developing disease is bunglesome, unscientific, and dangerous. However, all agree that massive infection or repeated contact with a bacillus-discharging case is to be avoided at all costs. Unlike the naturally or artificially acquired protection against smallpox or typhoid, the immunity against tuberculosis acquired through infection is probably never one hundred per cent complete. Resistance is only relative. In tuberculous infection, not merely toxicity but also numbers count. Massive infection is the important, perhaps the deciding factor and that factor can be controlled. What can be more fundamental, more essential in the tuberculosis campaign than to control the spreaders of tubercle bacilli?

"Control" is probably the best term to use, for we cannot chlorinate, pasteurize, trap, or swat the carriers of this particular communicable disease; they are human beings whose rights and personal liberty may not be violated. We cannot even successfully quarantine the victims of this chronic contagious disease except in a limited way by temporary isolation in a sanatorium. We can only exercise certain public health control over them through treatment, education, and sanitation.

DISCOVERY FIRST

Before the carriers can be controlled, they must be discovered. Unfortunately, the carriers or spreaders of tubercle bacilli bear no distinguishing marks; in

*Presented at the West Virginia State Health Conference, Charleston, November, 1934.

fact, many do not even know they are carriers. By what method shall we best discover them? To Dr. Hermann Biggs we are indebted for the system now in vogue of registering, on the records of the health department, cases of tuberculosis. In the face of none too tolerant skepticism and even bitter opposition, he caused tuberculosis to become a notifiable disease in New York City in 1897. Since then, practically every state in the Union has adopted the plan in one form or another. The theory on which the reporting plan is based is that sooner or later every tuberculosis patient falls into the hands of a doctor. If all doctors report all cases that come to notice, the health department will soon have a complete roster of the spreaders of tuberculosis. Reporting is a vast net spread over the community to catch the spreaders.

HOLES IN THE CONTROL NET

But apparently there are holes in this net; for example:

(*a*) Not all persons who have tuberculosis seek medical aid
(*b*) Some cases who do present themselves to the doctor are not correctly diagnosed
(*c*) Many delay their first visit and spread infection before a diagnosis is made
(*d*) Some doctors refuse to report
(*e*) Patients not wishing to be stigmatized as tuberculous prevail upon the doctor not to report.

Moreover, reports received by the health department are not always acted upon promptly. Occasionally, the complaint of physicians that cases reported are followed up tactlessly and to the detriment of the doctor's reputation, is justified. Dr. Robert E. Plunkett says: "There is rather general indifference on the part of health officials towards the enforcement of laws relating to the reporting and control of cases and the majority of physicians not engaged in tuberculosis practice are lax in complying with the public health law relating to reporting."

The appraisal form of the American Public Health Association sets as a desirable ratio two new cases reported annually for each annual death. Few communities attain that ratio. Among the reasons offered are:

(*a*) Indifference or an under-developed sense of responsibility toward the public
(*b*) A desire not to displease the patient who wishes to conceal the fact of his disease
(*c*) An unwillingness to permit health department agents to visit patients.

Too often, physicians are justified in saying that it is not worth while to report, for the record is merely entombed in a file or used for statistical purposes only. These objections can all be met, or at least mitigated by the health officer who is determined to control tuberculosis and who will assure the physician that every case will be followed up tactfully and in a manner not distasteful to the profession. Force achieves little—mutual understanding is the magic oil.

THE PUBLIC HEALTH NURSE—A HOUND ON THE TRAIL

In addition to the routine reporting by physicians, other means of securing information may be employed. The public health nurse, if she understands the epidemiology of tuberculosis, scents many a trail that leads eventually to a focus of infection. She should be coached in the technique of finding cases, and every "lead" that she may discover should be heeded and followed.

Nowadays, social workers find their way into many a tuberculosis problem. Tuberculosis is a family disease. Its close companions are poverty and social maladjustment. Is it not worth while to encourage these workers to be alert for evidence of tuberculosis and to report their suspicions to the health department?

The importance of the tuberculosis clinic as a case-finding measure is so firmly established and so well understood that it need but be mentioned.

The laboratory where sputum is examined furnishes the clue to many a case. Indeed, the health officer's responsibility for a case known to be a disseminator of tubercle bacilli is so clear as to require no further comment.

TUBERCULIN TEST AND X-RAY

The newer knowledge of childhood tuberculosis gives us another opportunity for finding cases. With the aid of the tuberculin test and the X-ray, we

can now discover the very early lesions of tuberculosis before serious damage has been sustained and before tubercle bacilli appear in the sputum. Based on Chadwick's study of 100,000 school children in Massachusetts, we may assume that almost five per cent of grade children will, if examined, show evidence of slight pulmonary damage or of massive infection.

Not all tuberculosis specialists will admit that these children are in peculiar jeopardy; that they are the candidates from whom tuberculosis will select its victims a few years hence; but all do agree that massive infection in a child implies contact with a source of infection. This source is generally to be found in the home. The real menace to the child is not the calcified nodules in his lung or tracheo-bronchial lymph nodes, but continued exposure to an open case. Here, then, is a promising way of locating spreaders of tuberculosis, and at the same time their contacts. Dr. F. E. Harrington, health commissioner of Minneapolis, reports that of the cases of active (adult type) tuberculosis now on the register of that city, twenty-four per cent were discovered by tracing them back through children with childhood type of tuberculosis.

If regional surveys of childhood tuberculosis were to be instituted wherever the trained personnel and the equipment are available, we should in time succeed in ferreting out practically every source of infection. Perhaps the best way to carry out such surveys is to make a tuberculin test of all children and then to X-ray the reactors. But even if the X-ray cannot be employed because of lack of qualified personnel or money, many foci of infection can undoubtedly be discovered by tracing each positively-reacting child back to his environment. It is a compromise measure worthy of consideration.

ISOLATION OF SPREADERS

Finding cases is only the beginning of "control." As a health-protective device the tuberculosis sanatorium has abundantly proved its worth. It provides the only humane method of isolating the spreaders of the disease. Even though all patients do not achieve a "cure" or complete arrestment, they learn while in the sanatorium how to care for themselves and, what is more important still, how to protect others with whom they associate.

There should be in every community at least one bed for each annual death from tuberculosis. This is an arbitrary ratio based on experience but lately this ratio has been attacked as being too low. Two beds per annual death is the goal in some enterprising communities. A better way to determine the number of beds necessary is to study the actual needs of a given community and to establish enough beds to meet those needs.

COLLAPSE THERAPY

The wider use of collapse therapy, particularly pneumothorax, is doing much to increase, relatively, our sanatorium capacity. Pneumothorax shortens the period of treatment and makes a quicker turnover possible. From the public health standpoint, the value of pneumothorax has not yet been fully appreciated. The two criteria by which any case of pneumothorax is judged are: (*a*) does it relieve symptoms such as fever, cough, expectoration, and (*b*) is the sputum rendered bacillus-free? Pneumothorax does, to a remarkable degree, render positive-sputum bearers, negative because by collapsing the cavities where pus is "manufactured" it quickly cuts off the supply of expectorated bacilli. Even though the patient is not completely cured by the operation, he is usually rendered bacillus-free and because of that fact ceases to be a menace to his fellowmen. Health officers should appreciate more fully the public health value of collapse therapy.

THE SANATORIUM FOR PROTECTION

Discussion still prevails as to whether or not tax-supported sanatoria should admit only the incipient or early cases and exclude the later stage cases. The theory in support of such limitation is that it is a waste of money to hospitalize the hopeless case. If sanatoria

were designed solely for the benefit of the individual patient, it would be proper to hospitalize only those who have a good chance of getting well. But such is not the case. The sanatorium exists primarily to protect the public—to stop the migration of tubercle bacilli. Therefore it is sheer folly to limit admission to early cases. It is the person in the second or third stage of tuberculosis who is most likely to be a bacillus spreader. He should be the first to be hospitalized and isolated if control of tuberculosis is our objective. The tax-supported sanatorium is primarily a public protection—not merely an asylum for the unfortunate nor yet an opportunity for the lucky individual whose disease has been discovered early.

Were we adequately equipped this difficult choice would be unnecessary. All who have tuberculosis should be hospitalized—the late case because he is a dangerous menace if left abroad, the early case because he, if untreated, may soon become a late case. And this brings us to a consideration of the evils of the waiting list. Half a loaf may be better than none, but one can scarcely conjure up a more flagrant example of waste than the typical waiting list of the sanatorium. It means that the flow of patients from infectivity to cure is perpetually interrupted. The waiting list is a dam holding back those who should be quickly admitted. And while they are so dammed up, for a period of months perhaps, the early cases among them quickly ripen into late cases. As late cases their prognosis is poorer and the time they will have to spend in the sanatorium is astonishingly increased. The sanatorium waiting list is an abomination. A sanatorium so handicapped is like a canning factory with insufficient capacity to process the fresh fruit as it is harvested. The bushels of tomatoes held back, spoil and the canning plant struggles constantly with incoming waste.

Those communities who are so unfortunate as to have no sanatorium facilities must not lose courage. They have first of all to meet the challenge by arousing public opinion to the need of a sanatorium. Meantime much can be done by good home treatment, provided public health nurses are available. Reasonably intelligent patients can learn how to safeguard others. Books and pamphlets for them exist in abundance.

There is no one easy way of controlling tuberculosis, yet the principle is a simple one. It is well expressed in the slogan, "Tuberculosis causes tuberculosis—every case comes from another."

LEADING ARTICLES IN THE AMERICAN JOURNAL OF NURSING FOR MARCH 1935

Mental Hygiene Education and its Value*

By CLARENCE M. HINCKS, M.D.
General Director, National Committee for Mental Hygiene

WE are discovering in the National Committee for Mental Hygiene that one of the most fruitful ways of promoting mental health work is through the psychiatric and mental hygiene training of workers and leaders in the domains of health, social work, education, and religion. And so we are placing our emphasis on education. To this end we have established a Division on Psychiatric Education affecting medical schools. We are now working toward the organization of a division that will affect policies for the selection and mental hygiene training of teachers in our elementary and high schools. And we hope to extend our program to other professional disciplines.

What is involved in the mental hygiene education of public health nurses? What should be our objectives?

A MENTAL HYGIENE POINT-OF-VIEW

It seems to me that our chief aim should be that of imparting a point-of-view—a mental hygiene or psychiatric point-of-view—as a diagnostic approach in reference to all human problems. Now, what is involved in this approach? It means that the public health nurse should view all health and social problems as human problems—that she should take into account mental, emotional, and situational factors as well as physical or economic factors in reference to every case with which she is called upon to deal. It means that she should forsake what Dr. Winternitz designates as "the guinea-pig school of medicine," wherein the human factor is left largely out of account. It means that effective help ofttimes can not be granted to individuals who are afflicted primarily with physical disabilities, if the attack is made from the physical angle alone. I heard an eminent professor of medicine say the other day that after twenty years' observation he had discovered that many physicians possessing half the technical general equipment of others but possessing a thoroughgoing mental hygiene approach were more effective in dealing with cases of human illness than were their so-called more scientific brethren. This truth holds for nurses. But of course we want in no way to minimize scientific training in all directions.

And this mental hygiene set of mind that we want to implant involves a keenness, not only to gain an understanding of human nature for the purpose of diagnosing individuals confronted with problems, but, in addition, a wholehearted urge to initiate therapy when indicated and, what is more important, to facilitate the prevention of mental ailments. It is most important that the nurse should be actively interested in positive mental hygiene—in the conservation and enrichment of the mental health of everyone in her community. This should be the central aim of public health endeavor in the mental hygiene field—the aim of fostering community arrangements that abet mental health and eliminating circumstances that provide a favorable atmosphere for the development of maladjustments. This preventive point-of-view involves, not alone the clinical approach, but takes into account our social, cultural, educational, industrial, and economic environment. It is the sanitary point-of-view as applied to mental hygiene.

SEVEN NECESSARY STEPS

To facilitate the development of this point-of-view and to equip the nurse for

*Presented at the public health nursing institute on mental hygiene, September 24, 1934, held in New York City under the auspices of the New York State Department of Health as an opening conference for those nurses participating in the extension course offered by the State. The subject for the course in 1934-35 is mental hygiene.

usefulness in the mental hygiene field, I have listed seven points that may be of importance and that might be included in an educational program.

The *first item* relates to the adjustment of the nurse herself.

If we would quicken the interest of the nurse in the whole subject of human behaviour and if we would attempt to facilitate her gaining insights into human nature and the problems of adjustment, we may be able to gain greatest headway at the start by having the nurse examine her own life and discover the nature of her adjustments and the degree of her mental health. I do not know of any process that is more humanizing than this, that creates greater sensitiveness to the problems of others and that develops a better attitude to mental hygiene work. If self-examination is left out of account, the worker's knowledge of mental hygiene may be confined to cold facts that she may not be in a position to use, and there is the danger that her attitude toward her clients may be marked by perhaps too much objectivity tinged with the suspicion of the strong helping the weak. The best mental hygiene worker, on the other hand, is the individual who identifies all vagaries of human behaviour with extremes of his or her own behaviour, who feels the existence of a common human bond with those confronted with problems, and who is thus placed in a strategic position to win confidence and to grant help.

If the nurse discovers a considerable degree of maladjustment upon critical self-examination, she can be fortified with the thought that the individual who has to win satisfactory adjustment through conscious effort or by other means may well turn out to be a more effective mental hygiene worker than one who has had no problem in this regard.

A *second objective* of our educational program should be directed to the subject of mental dynamics—to the ways in which the mind works, to the motivations of human conduct, to why people are what they are. Such phenomena as repression, projection, rationalization, sublimation, complex formation, habit formation and learning should be discussed with a wealth of clinical illustrations. While the psycho-analytic school has been prominent in bringing some of these phenomena to our attention, I feel that it is unnecessary to impart to the student much in the way of Freudian doctrine, especially in its more extreme forms.

And a *third item* might involve assisting the student in recognizing among her clients personality types when they are developed to a more or less marked degree. The nurse, for example, should be equipped so that she can recognize the defective and the markedly retarded, the paranoid, the anxious, the depressed, the excited, the explosive, the shut-in, the sensitive, and so on. Some facility in the diagnosis of personality types will help her in dealing with her clients and, indeed, with her friends and associates, and will make her more effective in picking out cases in the community that are in need of expert psychiatric treatment.

The *fourth item* that I have noted overlaps, to a degree, the one already mentioned. It is concerned with an attempt to make the nurse useful in contributing to early diagnosis and prompt treatment of incipient mental disorders. This constitutes a most important educational undertaking because the public health nurse frequently has a splendid opportunity to discover in the community those who are developing psychoses and psychoneuroses. And we all realize the fact that any advance that is made in bringing patients promptly under treatment will contribute greatly to therapeutic success. While it is not our aim to develop nurses to be expert diagnosticians, we want them to be sensitive to signs and symptoms of developing mental illness and to refer suspects to clinics and specialists. Training in this regard would involve reference to the symptomatology of the psychoses and of the psychoneuroses, and to the commoner signs of beginning failure of mental health.

The *fifth point* that I have listed relates to an attempt to give the nurse an

understanding of the conditions conducive to the mental health of children and of adults. Now what are these conditions?

THE CONDITIONS FOR MENTAL HEALTH

In our efforts to discover the major factors that are salutary for the achievement of mental health among children we are assisted by psychiatric experience in the study of those who have become maladjusted. Psychiatrists have found, for example, that such circumstances during childhood as the following may lay the groundwork for future disability: the development of feelings of inferiority, of a habit of failure, of the tendency to withdraw from the group, the development of timidities and fears, of feelings of insecurity, the possession of a narrow range of interests, and so on.

With such psychiatric evidence it would seem reasonable to draw conclusions that positive conditions for the attainment of mental health among children should include arrangements that promote self-confidence, self-respect, the making of many social contacts, the assumption of responsibility, the development of a wide range of interests, the acquisition of skills that can later be used vocationally and avocationally, etc.

In regard to the conditions for the mental health of adults there is involved work that makes a pull upon imagination and initiative; recreation, avocations, and interests that provide spice and variation to life; opportunities for healthy intimacies wherein the individual can merge his life with that of another with resulting satisfactions and the release of repressions; and the developing of a robust philosophy of life wherein life values and objectives become part of personal equipment. There might also be included in conditions for mental health the attainment of a sense of security. But this concept should not be pushed too far.

When the nurse possesses a familiarity with conditions leading to mental health, she will be able through her own ingenuity to assist many individuals to have fuller, richer, and healthier lives.

The *sixth point* of emphasis is the stimulation of the nurse, when she is equipped, to contribute to public education in mental hygiene. It is fundamental in the development of a positive mental hygiene program for the prevention of mental disabilities that the public be informed concerning ways of living that are conducive to the achievement of mental health. Such education will be recognized in the future as more and more a function of public health workers. And, in working toward this objective, the nurse can assist in the organization of parent education groups and of other groups, even if her training does not warrant actual leadership. She can import leadership from other quarters outside of her community or outside of the state.

And the *seventh item* I have listed is one of the most important of all. It relates to the whetting of the hunger of the nurse to familiarize herself with existing mental hygiene facilities in her community and to throw her weight into organized efforts toward the improvement and enlargement of these facilities. She can stimulate public appetite for better arrangements, and the nurse should be interested in this regard, not alone in diagnostic and therapeutic facilities—in clinics, hospitals, and training schools—but also in community arrangements that are important in the conservation of mental health—in recreation, in avocational guidance, in æsthetic pursuits, in primary and adult education, and so on. In viewing her community the nurse should ask: What are the facilities and opportunities for people of all age ranges for the satisfaction of the cravings of their natures, for healthy expression and development in music, in the arts, in sports, in intellectual pursuits, in human contacts?

I look forward to the day when our civilization will be constructed on the basis of making adequate provision for intrinsic human needs—for the needs of the mind as well as the body. And the nurse can work in this direction.

Lay Members' Responsibilities in Public Health Nursing*

By MARGARET H. WATKINS

President, Board of the Visiting Nurse Association, Detroit, Michigan

ON this occasion I hope I shall be able to inspire everyone to go home and persuade all her fellow board members that the very first and most important thing she should do is to join the State Organization for Public Health Nursing and the next most important item of her program is to join the parent organization, the National Organization for Public Health Nursing!

I shall try to point out some of the reasons why laymen ought to join with the nurses in group thinking on public health nursing problems.

Public health nursing in this country dates back more than fifty years. For at least thirty-five years in Michigan, and perhaps for a longer time, local groups of non-professional people have been interested in the problems of public health, but the development of statewide and national programs is a matter of comparatively recent origin. The National Organization for Public Health Nursing was organized in 1912 because of the demand for accepted standards of personnel, policy, and program. During the past ten years state organizations have been more or less perfected in more than twenty states.

Three years ago at the State Nurses' meeting in Saginaw, the board members of the visiting nurse associations of Saginaw, Bay City, Lansing, Detroit, and some other communities voted in favor of a state branch of the N.O.P.H.N. and a committee was appointed to carry out the plan. The matter was delayed, however, because it was stated that the public health section of the State Nurses' Association might organize itself into a S.O.P.H.N. and it seemed to the lay groups that it was preferable that the State organization should come about in this way. Last May at the meeting of the State Nurses' Association in Detroit, the organization of the Michigan S.O.P.H.N. was completed and now it remains for us to develop this organization so that it may be a real factor in public health matters in Michigan.

Membership in the State Organization is both professional and lay, the professional membership being based on certain professional standards, and the lay membership on citizen interests in the health and nursing problems. If the organization is to accomplish real results in Michigan, the membership, both professional and lay, must work together in active coöperation; the nurses, always remaining jealous of their professional standards, must, nevertheless, recognize that their nursing and health problems are only part of a general community welfare program and they must tell their problems and their plans to the lay members if they wish them, in turn, to counsel with them so that they may interpret those problems and needs to the community as a whole. If there is a lay section, may I beg you nurses not to leave the lay people with no interests but board organization, volunteers, and finances! Board education has been greatly developed in the last few years in all organizations, and all executives, I think, realize that the board members with their many various outside interests have much to offer and many contacts with the community which can be most useful to any organization.

*Presented at the meeting of the Michigan Organization for Public Health Nursing, Lansing, November 7, 1934.

WHAT CAN THE S.O.P.H.N. DO?

What definite program can a S.O.P.H.N. lay out for itself, and what may it hope to accomplish? First, it can establish a state-wide standard for public health nursing work. The N.O.P.H.N. sets standards for its membership and local corporate groups may be members only by meeting those standards. The State Organization can encourage the adoption of proper standards in every community and only allow those organizations which meet these standards to become members, which will give those organizations a national standing.

Second, it can develop city and county health programs and then, primarily through its lay membership, create and guide public opinion so as to insure the carrying out of the program. For example, in a certain county in the northern peninsula there was a well organized lay group, both men and women, interested in public health work. They knew what their nurse was doing and also how much she was saving the community by her work. When, recently, the local supervisors were engaged in necessary budget cutting this group was able to convince the supervisors that to cut the public health nursing program was false economy.

Third, through a legislative committee it can promote helpful legislation and fight any proposed legislation that may be harmful to public health interests.

Fourth, perhaps in time it may be able to employ a lay secretary, like Miss Evelyn Davis of the N.O.P.H.N., to stimulate citizen interest in local communities.

Fifth, the S.O.P.H.N. is now prepared to furnish local groups with a survey form compiled by the N.O.P.H.N. for use in local communities, which is a great aid in determining local needs and developing local programs.

RESPONSIBILITY OF THE BOARD MEMBER

These are some of the things that a state organization may hope to do, but it can never adequately function without the active support of an intelligent lay membership. The nurses, with their professional standards and their modern training, can do the work if they get the proper public support, but they cannot hope to get that support without the assistance of an organized lay body who knows their problems and their needs, and that organized lay body should be made up of the members of local visiting nurse association boards, local county boards, and hospital trustees. I believe it desirable to get hospital trustees in the S.O.P.H.N. where they may learn what we expect in nursing in the public health field and as a result may more adequately train nurses for work in that field.

For many years the greatest service that board members could render was the financing of the organizations, but with the development of the community chest idea and the increase in public health allotments from Federal and state funds, the money raising burden has been largely removed from the board, so now board members can and should pay more and more attention to what the nurses are thinking and doing, both individually and as a group; they should know the standards which should be required from public health organizations. Membership in a visiting nurse association board imposes an obligation on the members to have an intelligent understanding of the public health needs and of what other public health agencies are doing in the community, thus avoiding overlapping programs. Only if members have this understanding can they hope to perform one of their most essential duties—that of educating the public. Dr. Ellen C. Potter, in an article in the magazine, PUBLIC HEALTH NURSING,* stated it in this way:

> "The board of managers has a major function to perform in the education of the public as to the need of the work the agency is doing, as to its functions and the cost of rendering services, so that there is prepared a body of public opinion which can support the

*"Responsibility of Board Members," May, 1932.

work intelligently with dollars and with moral support."

Our membership on a board presupposes an interest in the work of the organization and the more we can inform ourselves as to that work the better we can do our job. A strong and active state organization with a large lay section will help each member greatly in the performance of his or her own duties. It is through strong lay support that both public and private agencies can best interpret their program to the public who have to pay the bill and who therefore are entitled to an intelligent presentation of the problems and the program.

MORE THAN A LOCAL VIEWPOINT

We should look at our local group through the eyes of the state and national organizations and judge our own standards by their standards. How many lay people here know the standards set for official agencies, such as health departments, and non-official agencies, such as visiting nurse associations and other private endeavors, and, if you know these standards, are you keeping them?

I urge each of you most strongly to join both the state and the national organizations and to endeavor to bring your fellow board members into the organizations. Only through a widespread lay membership in the state organization can it hope to accomplish its purposes as outlined at the last Biennial Convention:

> To develop a statewide consciousness of the needs and accomplishments of public health nursing in the state, thus helping toward a better distribution of service.
>
> To bring new stimulation and new information to the nurses and laymen in the interests of better standards.
>
> To act as a channel between state public health nursing services and national bodies through which generally accepted standards and new trends may flow.

Dialogue-of-the-Day

TRICHINOSIS

Public Health Nurse: Trichinosis, are you a worm, a fungus, or a germ?

Trichinosis: I am a parasitic worm with the musical name of *Trichinella spiralis*. My larvæ infest the muscle tissue of hogs and when people buy pork or any form of pork (sausages, etc.) from hogs that have become infested with me *and do not cook the pork thoroughly, then,* the gastric juice in the stomach digests the shell around my larvæ and frees me for action. The immature worms (about one-twenty-fifth of an inch long) go to the small intestine, grow to maturity and the fertilized female worms (an eighth of an inch long) enter the lining of the intestine to deposit their eggs. Their offspring are hatched about five days after eating the "measly" pork and enter the blood and lymph streams for distribution to all parts of the body. They come to rest in muscles, especially those of the diaphragm, ribs, eyes, and tongue. There they envelop themselves in capsules or cysts.

Public Health Nurse: Well, that's a life history for you! I have a lot of questions. How do the pigs get infested in the first place?

Trichinosis: Rats and mice are a link. They become infected with trichina worms from eating infested material and the pigs and hogs devour the rats or infested garbage and offal from slaughter houses. Microscopic examination of the meat reveals small oval areas or cysts. When properly inspected, infested pork should never reach the markets, but it is very difficult to detect. I "get by" a great many times.

Public Health Nurse: How do people know they have trichinosis? Has the pork a queer taste?

Trichinosis: No, people don't know they have eaten infested pork until—

usually—a few days later. Then they begin to be seriously or mildly ill, depending on the degree of infestation. High fever, profuse diaphoresis, diarrhea, sore throat, general malaise including sore, aching muscles, are usual symptoms. There may be abdominal pain and twitching of the muscles. The doctor should be called at once and after his diagnosis the health department notified in order to trace the infested meat. If the attack is severe, the muscular pains become acute, swallowing is difficult, the eyes are inflamed, sometimes the respiratory difficulties amount to dyspnœa and asthmatic attacks due to the invasion of the intercostal muscles. Edema characterizes the third stage and skin eruptions. Pneumonia is a complication. In the severe cases death may take place in the fourth to sixth week.

Public Health Nurse: I know about your treatment. People usually see their physician too late to be given an anthelmintic, so all we can do is treat the symptoms. Some of the lighter cases, and most of them are that, recover and may not even be diagnosed. I know, too, that Germans and Italians are rather apt to have the disease because they eat pork in raw forms, and I know hamburger steak (chopped meat) may have scraps of raw pork added to it, so that thorough cooking is again indicated. They say trichinosis cases follow the national holidays and may appear in whole parties of people. What should people do to avoid becoming infested?

Trichinosis:

(1) Never eat raw pork in any form.
(2) *Cook all pork in all forms thoroughly all the way through.*
(3) Trade at reputable, clean markets which are purchasing their meats from large packing houses which know how to select, cure, and dry the animals and keep at proper refrigeration.
(4) Buy meat bearing the stamp of official inspection.
(5) Be sure your doctor reports at once any diagnosed case to the health department.

Public Health Nurse: And I suppose a general improvement in sanitation of all kinds all over the country especially around slaughter houses, would do a lot toward eliminating cases of trichinosis. You've been very generous in telling how to get rid of yourself, Trichinosis, won't that be suicidal?

Trichinosis: Dear me, how stupid, I forgot to whom I was talking! I've been a little pig-headed since Mr. Walter Disney has been putting my host in the movies. You won't tell any one, will you, Nurse?

Public Health Nurse: Every one—especially cooks!

Material for this dialogue gathered from the following sources:

Weekly Health Message, United States Public Health Service and Iowa State Department of Health. No. 429, January, 1934.

United States Department of Agriculture Leaflet No. 34, Washington, D. C.

Five Years' Experience with Trichinosis in New York City, 1929-33. U. S. P. H. S. July 27, 1934.

Trichinosis of Man a Common Infection. Wm. A. Riley, M.D. Charles H. Scheifley, B.A. Journal of the A.M.A., April 14, 1934.

The FERA Nursing Program in Florida*

By RUTH E. METTINGER
Director, Division of Public Health Nursing, Florida State Board of Health

AT the State Nurses' meeting in November, 1933, the Florida Emergency Relief Administration asked that plans be drawn up whereby clients of Emergency Relief could receive nursing care at a minimum cost. A plan was submitted suggesting that all nursing service of the ERA be placed under the direction and supervision of the State Board of Health. This plan was accepted by the Florida Relief Administration. The Executive Board of the State Nurses' Association was asked to appoint a committee in each district to list the nurses in need of employment. These lists were submitted to the State Board of Health, Bureau of Public Health Nursing, and used as the basis of selection of the ERA nurses. It was learned that over two hundred nurses in Florida had been unemployed for a period of six months to a year and many were on direct relief.

By February 1, 1934, all local ERA nursing projects were discontinued and a State project was started under the supervision of the State Board of Health. It is the general consensus of opinion that hospital training is not sufficient preparation for public health nurses. Since this project was promoted primarily for unemployed graduate nurses, it was impossible to secure nurses especially trained in public health. Therefore, fifteen district supervisors with public health training and experience were placed at central points throughout the State to supervise and assist the nurses with the program. A generalized public health nursing program was worked out which included visiting nursing, physical inspection of children in families receiving relief or in need though not on relief, and referral for medical examination of children with evident need for correction or treatment.

WHAT THE NURSES DO

Nurses were instructed:

To make inspections in the homes so that all children in the families would be seen

To arrange for and assist with the medical examinations of selected children by local physicians participating in the program

To arrange for correction of defects as ordered by physicians or dentists

To follow up children needing further instruction on nutrition or other specific health problems

To determine the general health status of children of families on relief and of families in need though not on relief, to determine abnormal conditions of nutrition, physical defects, and other specific problems

To ascertain whether arrangements had been made for medical care and supervision of prenatal cases under the doctor's orders

To see that as far as possible prospective mothers had obstetrical packs so that the physician or midwife might do their best work.

To distribute prenatal and communicable disease literature furnished by the State Board of Health

To work out in detail in coöperation with the County Medical Society a program for vaccinations and immunizations in communities where it was needed.

While a community public health nursing program is conducted, the FERA client in need of nursing care is the first consideration. Where possible, one member of the family is taught to give a bath or enema, to take the temperature, or make the bed. The importance of following the doctor's instructions as to diet, medication, hygiene, and sanitation is stressed also.

At the beginning, each nurse was advised to secure a copy of the N.O.P.H.N. Manual of Public Health Nursing, a copy of the State health laws and regulations, and the national, state, and local relief regulations. The nurses were instructed to conduct classes in home hygiene and care of the sick when possible, including simple procedures for home nursing, community and home sanitation, care of the infant and pre-

*Presented at the Florida Public Health Association meeting, Jacksonville, December 4, 1934.

school child, and control of communicable disease.

Immediately after the assignment of the nurses to a county, the Medical Society was given a copy of "standing orders" covering simple care and treatment of patients, with the request that these be reviewed and, if approved, signed by the president and returned to the nurse. These orders serve as a guide to the nurse on the first visit if a physician is not in attendance. Repeated visits to the patient are not made unless a physician is called. If a patient is in need of a doctor, the Social Service Director is notified and she requests the services of a physician. Upon the assignment of a physician, the nurse immediately gets in touch with him to receive definite instructions as to the nursing care desired.

Because the maternal death rate in Florida was extremely high, special stress was laid on the prenatal, infant, and preschool program. Through prenatal classes and individual visits, the patients were advised about the proper prenatal care, preparation for delivery, and care after delivery. This advice was given of course under the supervision of a physician. Since this program was instituted, there has been a 33 per cent decline in the maternal death rate.

BETTER PREPARATION

As the nursing service progressed, the need of more training was realized. Therefore, before assigning a nurse to a county, she was placed for a period of three weeks on the staff of the Visiting Nurse Association in Jacksonville or in Tampa where she received lectures in public health nursing. She is also given experience in home visiting, rural school nursing, clinic service, and observes classes in home hygiene and care of the sick. The nurses who were assigned to duty without this training have asked for it. We are hoping to increase the training period to six weeks.

Once a month each supervisor holds a one-day institute with the nurses in her territory, using as her textbook the N.O.P.H.N. Manual of Public Health Nursing. In addition, there have been three special institutes conducted by representatives from the N.O.P.H.N., the American Red Cross, and the National Society for the Prevention of Blindness. Two midwife institutes have been held, at which time the FERA nurses have been requested to attend to further their training in this phase of the work.

OTHER ACTIVITIES

Where nursery schools are operated for the care of the children of mothers on FERA work projects, the nurses make regular visits for the health supervision of the children—weigh, measure, and inspect and follow the children into the homes to give advice and help arrange for the correction of defects and assist the mothers with their feeding problems. "Standing orders" for the teacher's guidance are secured from the local physicians. The nurse interprets and instructs the teachers in the execution of these orders.

Other duties of the FERA nurses include weekly visits to the mattress factories for health supervision of the women employed, excluding from duty any that have evidence of skin disease or other ailments. The employees are permitted to return to work on the authority of a physician to whom they are referred.

Due to the demands made upon the State Board of Health for specimen containers and laboratory service, it has been necessary to encourage cities and counties to purchase hookworm containers; 97,699 specimens were submitted in a period of ten months.

Ten FERA nurses have been assigned on regular duty in hospitals caring for relief patients.

One nurse or more has been assigned to every county in the State; the total number is 259 graduate registered nurses. On special request and with the approval of the Director, special duty nurses may be assigned to serious cases. This special duty service is limited and the family is required to assume responsibility for nursing care under the guid-

ance of the visiting nurse. The home hygiene teaching has proved of definite value in supplementing the service of the FERA nurses.

LOOKING TOWARD THE FUTURE

To build for permanency in this program after and when Federal Emergency Relief funds are withdrawn, public health nursing committees of lay people have been organized in sixty of the counties. These committees have assisted the nurse in securing equipment for home hygiene classes and supplies which are needed in her program. They meet once a month, at which time the nurse gives her monthly report. In two counties an appropriation has been made by the commissioners to continue the work.

A permanent Visiting Nurse Society has been organized in Duval County. At the first meeting a group of interested persons were invited to discuss the organization. Committees were designated to draw up constitutions and bylaws, to contact the business firms who might use this service, and to determine the extent to which they might contribute. A committee of physicians secured the endorsement of the County Medical Society and helped to outline the policy of the Visiting Nurse Society to conform to the wishes of the Medical Society. Another committee drafted a budget and suggested sources of funds. The organization was completed and permanent officers elected but activities are not to begin until the present FERA visiting nurse work is discontinued.

The services of the FERA nurses, though they have not reached perfection, have been of great value to the community and stimulated a health consciousness among the general public. Furthermore, the nurses themselves have not only found employment but their interest in and understanding of public health nursing have been enhanced immeasurably.

REFERENCES TO E R A MATERIAL

A list of references to ERA material published in this magazine, 1933 to date:

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Nurses on Relief Basis—Cost Accounting—May, p. 305
TERA Experiment in Double Relief—New York—July, p. 378
TERA Nurses—Syracuse—August, p. 445
TERA Nurses—Rochester—August, p. 446
TERA Nurses—Yonkers—August, p. 449
NRA and Nursing—September, p. 465
Public Health Nurses and Relief Giving—November, p. 589
Nursing of Those on Relief—FERA Rulings No. 7—November, p. 587; December, p. 635
Public Health Nurses and the Code—December, p. 633

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CWA projects—February, p. 65
Information for CWS Nurses—March, p. 115
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Significance of FERA to Public Health Nursing Programs—October, p. 515
Nursing in a Camp for Homeless Men—November, p. 593
Experiences of an ERA Nurse, Utah—December, p. 665
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Nursing Relief Clients—Philadelphia—February, p. 63

Citizen Participation in a School Health Program

By MABEL M. BROWN, R.N.
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HAD Reading, Massachusetts, been included in the twenty-eight communities in the N.O.P.H.N. "Survey of Public Health Nursing," the total score for boards of education using organized lay groups and volunteer service would have been increased by one, for Reading has had citizen participation in its school health program for the past fourteen years.

The history of this particular community relationship goes back to the beginning of school nursing in Reading, in fact, a bit prior to it. When in the post war days, the Red Cross was in the now inconceivable state of searching about for ways and means of spending its money, it was suggested to the local branch by the executive secretary of the department of health that a survey of community needs be made. This was done in the spring of 1920 by a student from the School of Public Health Nursing, Simmons College, Boston, and was paid for by the tuberculosis committee. Among the recommendations was the employment of a school nurse as a demonstration project. The school committee was approached and was enthusiastic, so that in the fall of 1920 a nurse was placed in the schools, her salary being paid by the Red Cross and one month by the Tuberculosis Committee.

Before the appointment of the nurse, a committee was formed, called the Red Cross and Good Health Committee, which had as its chairman, the head of the Tuberculosis Committee, and for its members, the Superintendent of Schools, the Chairman of the Board of Health, the assistant-treasurer and the visitor of the social service department of the Red Cross, a representative from the Public Health Section of the Women's Club, the Community Service of the Grange, the Legion Auxiliary, the Visiting Nurse Association and a representative from each of the churches in town. The chairman of the committee selected the nurse who was jointly responsible, that year, to the Superintendent of Schools and the local committee.

IN THE EARLY DAYS

The first year was full of the usual joys and vicissitudes for a new nurse starting a pioneer work, but back of it all was this representative committee that was of inestimable value in helping to interpret the community to the nurse, and, likewise, to interpret the work of the nurse to the community.

Monthly meetings were held through which the committee became familiar with the nurse's work and her problems. Reading, it might be well to explain, is a typical, residential New England community of about ten thousand inhabitants, most of whom, at least back in the days of 1920-21, belonged to the comfortable middle class, but even then, there was an appreciable number of parents who were financially unable to meet their responsibilities. As a result, there was the usual tonsil operation to be paid for, glasses to be bought and milk to be provided for needy children. Always, that first year, it was possible to take care of such emergencies within the committee through either Red Cross or tuberculosis funds. Later, it was not always possible for these two organizations to meet all the financial demands upon them. The committee then became responsible for raising funds, either through soliciting them from other organizations or by special money raising projects. This is now done annually when children are sent to camp, where the amount of money involved is

large. While the Good Health Committee nominally sends the children, the money is collected from various agencies and interested individuals. A fund for eye glasses has been created recently in a similar way.

Many of the activities the first year required not only the financial help of the committee, but the personal service of its members. The town was without a dental clinic at the time, which necessitated taking children to clinics in Boston. Each appointment day, a member went with the nurse in order to have children whose work was completed early brought home and thus saved an unnecessary loss of school time. This practice, more than any other single factor, hastened the establishment of our own dental clinic.

INTERDEPENDENCE OF OFFICIAL AND NON-OFFICIAL AGENCIES

In the following September, when the nurse was taken over by the school committee, the interdependence of the official and non-official agency had been clearly demonstrated. It had been shown that, if the work of the nurse was to be fully effective, there were times when her program would need personal and financial assistance, neither of which would be available in the school set-up. Moreover, plans were well under way for the establishment, that fall, of a dental clinic with the Red Cross funds which were released by the school's taking over the nurse. The school had agreed to lend the nurse for one day a week to get the clinic started. Later, her function in regard to the clinic was that of supervision, passing on new cases and making regular reports of the clinic work to the committee. Thus the relationship between the nurse and the lay group became more firmly cemented. It was decided to continue the monthly meetings and to continue to work on the same coöperative basis.

As the health work in the school developed, the demands upon the lay committee increased, and the scope of its service broadened. It is interesting to note that, as time went on, the school's need for the personal service assistance of the committee developed beyond that which involved its financial help.

SPECIAL PROJECTS OF THE COMMITTEE

One of the most interesting pieces of work in which the committee has participated was the demonstration clinics, which were held in Reading in 1923, previous to the beginning of the ten-year program of tuberculosis prevention in the schools of the State. Dr. Sumner Remick, then head of the Division of Tuberculosis, State Department of Health, personally supervised the clinics, and the Good Health Committee assisted in many ways, such as taking histories, getting children ready for examination, greeting parents, and giving publicity to the work. Since then, the committee has helped with the Chadwick Clinic in similar capacities.

Another participation program which has become a part of the annual activities of the committee is the diphtheria prevention work. When the school started its annual immunization program in 1923, there was need of a large number of lay assistants to assure the efficient operation of the clinics. Once more the Good Health Committee members responded and were able to contribute both clerical and professional assistance, since two of their members were nurses before marriage. At first only the assistance of the organized committee group was used; later, volunteers were used, thus increasing the number and range of lay people who had the opportunity of becoming familiar with diphtheria prevention work through actual experience. Today it is possible for the nurse to call the chairman, tell her the clinic days, the approximate number of children expected, and the type of work to be done with the full assurance that on the day of the clinic each helper will be in her respective position, prepared for the job in hand.

From the school's point of view, probably the greatest contribution to the school health program, which the Reading Good Health Committee has made was the establishment of a posture clinic. When in 1928, the school started an intensive posture campaign to les-

sen the number of postural defects that were found each year through the health examination, the work was hindered by the lack of facilities for expert medical supervision of the structural and congenital cases. It was neither desirable nor permissible by law for the school to undertake such a project. The matter was presented to the committee with the result that the services of a leading orthopedic specialist were secured, and a clinic was held once a month throughout the year. Since that time, the posture clinic has served as an adjunct to the corrective posture program in the school. The responsibility for follow-up incident to the clinic is shared by the nursing and physical education staffs of the school. The Good Health Committee has assumed the financial responsibility for needy cases, which in some instances has meant paying for appliances. Several cases that have needed operative treatment have been cared for by a special hospital fund created by a late philanthropic citizen.

AS AN AUXILIARY AGENT OF THE SCHOOL HEALTH DEPARTMENT

It would be impossible to enumerate and elaborate upon all the ways in which citizen participation has helped to develop our school health work. After fourteen years of service, the organized group has become definitely identified with the health department as its auxiliary agent. While the name of the Committee has been changed from the Red Cross Good Health Committee to the Reading Good Health Committee, the representation on it is essentially the same. Many of the original members are still on the committee; two of the members, at times, have served concurrently on the Good Health Committee and the school committee, a factor which makes them particularly valuable in seeing the health problem from both the school and community standpoints. The present chairman has been in office since the organization of the group. Her leadership and enthusiasm for school health work have been largely responsible for the efficient way in which the committee has functioned through the years.

Volunteers have been increasingly used, but always they are recruited and assigned to their work by the chairman of the organized group. This fall, volunteers have been used to advantage at the time of the annual health examination, when the taking of the ACH index of the elementary school children made clerical assistance imperative. Volunteer motor service has always been used, as well as volunteers for taking children to clinics in the early days of the school nursing program.

AN EXAMPLE OF HOW IT WORKS

A good example of how the health program of the school has come to be looked upon as a community project through the instrumentality of the Reading Good Health Committee is the following story:

In coöperation with the State Department of Public Health, the school health service was desirous of having a dental-nutritional survey this fall as a part of its dental program. The school committee had approved the project provided no expense was to be involved. Plans had been carefully formulated. The State consultant in dental hygiene was directing the work, a nutritionist from the same department had been promised to help with the important work of follow-up, and Dr. Mark Elliott of Forsyth Dental Infirmary, Boston, was collaborating. But when it came to arranging for the examination of the pupils' teeth by a dentist, there seemed to be no way out! The school did not have a dentist and the dentist at the clinic was paid in part by town appropriation and, therefore, could not be used for this purpose. What to do?

The problem was taken by the nurse to the Good Health Committee and the purpose of the survey was explained. The committee was interested and enthusiastic, but their funds were low. There was a whispered conversation between two of the members, who happened to be the president of the Visiting Nurse Association and the chairman of the preschool clinic, which enterprise is sponsored by the former organization. Presently, it was suggested by the pres-

ident of the V.N.A. that, whereas the latter was feeling a bit affluent because of a recent legacy, and whereas the Reading Good Health Committee was particularly low in funds, would it not be in order to suggest to the V.N.A. that the money that is annually appropriated by the Good Health Committee to the preschool clinic be reappropriated this year to the Dental-Nutritional Survey. On the strength of this, the committee moved that the suggestion be brought before the V.N.A and that the director of health of the schools be invited to present the matter to the association. This was done at the next meeting, and the reappropriation of the money was unanimously voted. In the words of the cartoonist Briggs, it is "a grand and glorious feeling" when one association is interested in the work of another to the extent of foregoing its appropriation in favor of the other.

TANGIBLE AND INTANGIBLE BENEFITS OF CITIZEN PARTICIPATION

It is difficult to evaluate statistically the results of the working together of official and non-official health agencies in any community. Many of the results are intangible and evade evaluation. It is generally recognized, however, that the public health work of any community develops to its fullest extent only when there is such coöperation.

As a result of citizen participation in our own school health program, a threefold interest can be noted: It has helped the school to meet pupil and community needs, especially in regard to its remedial program. From a community standpoint, it has resulted in there being a larger number of citizens, who are intelligently interested in what the school is attempting to do for the health of the children; and, because of the broad representation on the Reading Good Health Committee, it has resulted in there being more organizations in town that are similarly well informed as to the school's part in the health work of the community. From the point of view of the Reading Good Health Committee, participation has given the group intelligent direction and has provided it with an opportunity for purposeful activity. By so doing it has increased the scope of the committee's service that otherwise might have been limited and mediocre in character.

Coöperation Between Metropolitan Life Insurance Agents and Public Health Nurses

By CATHERINE O'CONNELL TRACY, R.N.
Supervisor, Providence District Nursing Association, Rhode Island

One of the most unique developments in social and health work in the United States has been the coöperative plan worked out between insurance companies and visiting nurse associations, by which certain groups of policyholders with policies in good standing are given nursing care in their own homes by local visiting nursing staffs. This plan was conceived by the late Dr. Lee K. Frankel of the Metropolitan Life Insurance Company and started in a small way in 1909. At the present time more than 1,500 visiting nurse associations hold contracts with various insurance companies, of which the Metropolitan Life Insurance Company and the John Hancock Mutual Life Insurance Company are the two largest groups. Naturally, a smooth working relationship locally between the insurance agents and the visiting nurses is essential in running the kind of service acceptable to policyholders and in developing every opportunity to do an effective piece of preventive work. It is therefore worth while to learn how one very successful relationship has developed over the years. Some nursing agencies may find helpful suggestions to apply to their situations in this report from Providence, Rhode Island.—*The Editors.*

IN April, 1910, the Providence District Nursing Association entered into an agreement with the Metropolitan Life Insurance Company to furnish nursing service to its policyholders for which the Company agreed to pay the Association fifty cents per visit.

Preceding the signing of the contract several conferences, attended by Miss Mary S. Gardner, representing the Nursing Association, Dr. Lee K. Frankel and the superintendents of the local district offices, representing the Metropolitan Life Insurance Company, were held, and the Board of Managers of the Providence District Nursing Association gave much time to considering the establishment of such a relationship.

In the beginning there were certain objections to the plan by a few physicians and by some of the policyholders, the latter fearing that the fees paid to the nursing association would eventually be deducted from the face value of their policies. These objections were soon overcome by explanations to both physicians and policyholders.

Education of the staff nurses and the agents in the new arrangement was started immediately for it was recognized that the success of the plan would depend almost entirely upon the understanding and coöperation of these two groups. The nurses were instructed to become acquainted with the agents working in their districts and to seek their coöperation in referring cases on their debits for nursing care when needed, and the agents likewise were urged to know the nurses by name and to confer with them from time to time about the service.

Throughout these twenty-five years there has been developed a spirit of mutual understanding, coöperation, and friendly relationship between the Metropolitan Life Insurance Company and the Providence District Nursing Association, and the agents have, from time to time as a group, taken an active part in campaigns for raising funds to support the regular work of the nursing association.

The agents are seen frequently, and at least once a year (at the beginning of the plan more often) the Director has visited the local insurance offices to discuss the work with the superintendents and the agents. Arrangements for these visits are made through the super-

intendents, all of whom are enthusiastic and cordial, and welcome the Director of the Nursing Service in true Metropolitan style.

WHAT THE NURSE DIRECTOR TALKS ABOUT

The talk is always preceded and followed by loud applause, singing, and three cheers. In her talk the Director gives a brief outline of the history of the beginning of the service by the Company and presents a few of the Company's statistics showing what the nursing work has helped the Company to accomplish for its policyholders, and a few of the Association figures are quoted showing what the Insurance Company has aided it to accomplish for the community. The Nursing Manual is reviewed and the policy of the company in regard to certain types of illness is explained, the types of policies that entitle the holders to nursing care and the length of time that they must be in force before maternity care can be given. The most common sins of omission and commission are discussed, and the agents are urged to tell their policyholders about the service and to distribute the leaflet, "Answering the Call." They are asked not to promise unlimited nursing care or numbers of visits on any given case. If in doubt the agent is advised to tell the policyholder that he is not sure just what the company will do in the particular case but that he will send the nurse who will explain the matter in detail. The following facts are reviewed and emphasized:

1. That the Company does not pay for nursing care at the time of delivery, but that the Nursing Association does offer such a service
2. That the Company will not pay for a series of hypodermic injections to patients who are up and about, with the exception of a few visits for the purpose of instruction in giving insulin
3. That visits to chronically ill patients are limited to six, which are for the purpose of demonstration and instruction. (In exceptional cases the Company will sometimes allow further care)
4. That continued health instruction visits are not paid for by the Company
5. That the services of a nurse for assisting at an operation or giving ether will not be paid for by the Company
6. That policies must have been in force six months before their holders are entitled to maternity care, with the exception of group certificate holders.

These points always create most interesting discussion.

The Director tells the story of four or five agents in the past who had promised nursing care of a type not paid for by the Insurance Company. This care was later demanded by the policyholders at the Company's expense because the agents had assured them that the Company would pay for it. The agents in question, when informed that the Nursing Association would refer the matter of payment to the Home Office, the bills, amounting to $5 or $6, were paid by the agents out of their own pockets.

SOME OF THE STICKING POINTS

Rules governing the service from the point of view of both the nursing association and the insurance company are gone over in detail. The fact that the nurse cannot visit a patient more than twice when not under the care of a physician is difficult for some of the agents to understand. The agent's point of view, like so many other people in the community, is often "discharge the doctor and let the nurse do the dressing." The health pamphlets published by the Company are referred to and the agents urged to distribute them freely among their policyholders.

The importance of early reporting of cases is emphasized, the agent being asked to teach the family when in need of a nurse, to call the nursing office themselves.

Why it is important that the patient have the policy and premium receipt book ready for the nurse on her first visit is explained.

The Director confesses that nurses, as well as agents, sometimes make mistakes, and this acknowledgment seems to give unlimited consolation! The agents are invited to come to the nursing office with any complaint or dissatisfaction they may have of the work in their district at any time, and occasionally the agent does come to question why the nurse does certain things. An

appointment is then made for him to have a conference with the nurse and the Director, after which he usually leaves the office satisfied.

When the nurse reports that an agent has promised a policyholder the impossible, the Director gets in touch with him and insists that he meet the nurse at the home of the patient and acknowledge his mistake. If he refuses to do this, the matter is taken up with his superintendent.

THE WEEKLY VISIT

An important factor in maintaining friendly relationships and understanding of each other's problems, is the weekly visit to the insurance company offices when the agents are all assembled. Every Saturday morning the supervisors in rotation visit each of the five district offices. Both agents and nurses take advantage of this contact through the supervisor to straighten out any misunderstandings or difficulties that may have arisen during the week. Friendly relationship, and a spirit of coöperation between the nursing organization and the Metropolitan Life Insurance Company are strengthened or weakened largely according to the degree of understanding of each other's objectives on the part of the agent and the staff nurse.

AIR AMBULANCE SERVICE

The value of air ambulances for the transport of the sick and wounded in time of peace and war is no longer in doubt. To the Swedish Red Cross belongs the honor of having taken the initiative for establishing a permanent civil air ambulance service, and its example has been followed by many other countries, notably France, Finland, Greece, Siam, and Australia. It is not too much to predict, therefore, that in the near future this type of service will become one of the regular activities of Red Cross Societies.

One of the earliest pioneers was Mlle. Marie Marvingt, Vice Présidente des Amis de l'Aviainto Sanitaire, herself a nurse, who obtained an air pilot's certificate in those early days (1910) when, for a woman to do so, was nothing short of heroism. At the Second Congress on Air Ambulances in Madrid held in 1933, she insisted on the importance of the nurse in a well-organized air ambulance service, and brought forward a resolution urging that facilities be accorded to nurses to train for this service.

Nurses are submitted to a careful medical examination and, if passed as physically fit, are given twelve hours of flying under varying conditions, including flying above three thousand meters. The last three hours are spent in military ambulance aeroplanes in which the nurses are called upon to carry out certain nursing procedures and to answer questions in writing handed to them in a sealed envelope.

The French Red Cross has recently issued a special "carnet de vol" to nurses training for this service; it shows the date and duration of the flight, the name of the pilot, and provides for observations.

The efforts of the French Red Cross are directed not so much to training nurses specialized solely for air ambulance work as to increasing the efficiency and technical knowledge of picked members of its nursing staff so that they may be able to serve as air escorts when needed.

In conclusion, it must be made quite clear that the training of nurses as air escorts—like the air ambulance itself—is still at the experimental stage. Theories and programs for nursing training will doubtless evolve simultaneously with the general problem of air ambulances.

—Excerpts from an article by Mrs. Maynard Carter, Chief, Nursing Division, League of Red Cross Societies, in its Bulletin, January, 1935.

South Carolina

Presents the

NURSE-OF-THE-MONTH FOR MARCH

MARGARET HARRY

I WAS taking a nurse's training course in the Massachusetts General Hospital when the World War was going on. Then in the Spring of 1920 I went into the heart of the Southern Appalachian Mountains to work, and

for eight years I practiced my profession there. I could not have chosen a field more fertile in satisfactory results. A legend survives that this was the country of my forefathers, who helped to settle and to subdue the wilderness. Thus an inherent affection and an inner understanding caused me to cling to this land of my ancestors and to its people.

Late one cold March afternoon I left the railway station, riding in a horse-drawn vehicle over dirt roads, for a destination which was some eighteen miles away. A biting wind slapped at my cheeks and cracked the branches of trees against one another under the dark heavens as we meandered over the lonesome trail. Night settled over the land, and a star or two came out and blinked at me strangely. Dismal peaks grew black and very high; the winding trail led over tall mountains, through deep gaps, and across narrow valleys to a hamlet on a plateau within a stone's throw of the crest of the Blue Ridge.

Here, through crystalline air, over bypaths and roadways, I went from settlement to settlement, doing preventive and curative nursing wherever I was needed. Traveling was on foot . . . five, ten, twenty, or even thirty miles in the course of a day, and sometimes night would envelop me when a stretch of many miles lay between me and the next hamlet.

Everywhere I found children in need of education. Today many of them are finishing high school and college courses. Through them better health will be spread to many people, perhaps not scientifically, but at least intelligently. Of all my work, I treasure most the chance to encourage education for these underprivileged children, for in them lies the hope of the future.

The Oconee County Health Department where I am working now was organized in 1929 and carries on a generalized program in prophylaxis and health education. The unit has three divisions: executive, clerical, and nurs-

ing. There was a sanitary inspector for a part of this year and the work has been an ever-widening health service for the people.

Oconee County is the westernmost tip of the State of South Carolina. The area is 650 square miles, 200 of which are mountain land, and 450 undulated terrain. A portion of the Nantahala National Forest lies in this region. The lower half of the county is agricultural, and some of the finest apples found in the United States are grown here. The main line of the Southern Railway runs through it, and all parts are accessible because of good roads. The county is industrial as well as agricultural, with five cotton mills within its boundaries. It is urban and rural. The population is 33,365, of which 6,398 are Negroes.

There are twenty-three resident physicians in the county, twenty of whom do active practice, but there is no hospital or facilities for caring for the sick outside the home.

Of special interest this past year are these developments in the general program:

1. The incidence of measles was considerably above the usual expectancy and not all cases were isolated and quarantined. Many families were unable to pay for medical service, and when such instances were met, advice relative to treatment and nursing care was given.

2. A diphtheria campaign was instituted and many children throughout the country were reached and immunized against the disease with one-dose toxoid.

3. A few cases of typhoid fever appeared in the county during the year. Each case increased the possibility of prevention by stimulating those of the community to request an anti-typhoid clinic in their neighborhood where they might take the preventive treatment.

4. Parents no longer resent the requirement by the State that the child entering school must be vaccinated against smallpox. During the year 795 children were given the anti-smallpox vaccination.

5. In health conservation the field of venereal disease control has not been so thoroughly developed as it might be. Examinations and advice were given a number of cases, and booklets on the diseases have been obtained from the Health Department.

6. The battle against tuberculosis has been an up-hill fight, and prevention of the disease remains the fundamental problem. The spread of health information, diligent contact follow-up, and the segregation of cases by placing them in the State Tuberculosis Sanatorium have been effective.

7. Hookworm.—Intensive education over a period of years has reduced the incidence of hookworm to that of very few cases. Families afflicted with the disease were instructed in sanitation and control of it, and treatment was given.

8. During the past year a Civil Works Administration Sanitary Pit Privy Construction Program was undertaken in South Carolina and other states. The work resulted in 846 privies being built in this county.

9. Orthopedic. — Crippled children have been given a chance in life through corrections and work done for them in the Shriners' Hospital of Greenville. For those unable to pay for transportation back and forth, it was provided by the Federal Emergency Relief Administration, Red Cross, and interested individuals.

10. Pellagra.—There has been a marked reduction in the incidence of the disease over that of last year. The Federal Emergency Relief Administration has coöperated and given yeast to those unable to buy it, and in many instances a pellagra diet was provided.

11. There are thirty practicing midwives in this county. Their knowledge of obstetrics is limited but under the supervision and requirements of the State Board of Health and the local Health Department they have improved in technique and work in competition with one another. Their standard of work has been raised, a sense of responsibility has been aroused, and they are registered and licensed by the State.

Five Years of Work in Athens, Greece

A DEMONSTRATION IN PUBLIC HEALTH NURSING SERVICE

By MARY COBURN

This article describes the work in Greece of Miss Alice G. Carr, director of the health program of the Near East Foundation. Miss Carr is a native of Ohio, and a Johns Hopkins graduate. She went to France in April, 1917, as a member of the first medical unit of Johns Hopkins Hospital. After the war she was with the Red Cross in Austria, Poland, and Czecho-Slovakia. She was in this country last Spring on her first home furlough since 1923 when she went into Greece to work for the Near Eastern refugees.

She has been decorated three times by the Greek Government. The first recognition came in the early days of her service when a million and a half refugees from Asia Minor poured into Greece and Miss Carr was directing health work in orphanages which housed 17,000 destitute children. In the Fall of 1933 Miss Carr received a gold medal as the Near East Foundation's health representative for eleven years of continuous service for the Near Eastern people, and the Silver Cross of the Order of the Phoenix has been conferred upon her for her fight against tuberculosis which, during the years following the great influx of refugees, reached epidemic proportions in Greece.

Miss Carr has recently transferred her health project in Athens to native direction and support. She has made a survey of health and home conditions in villages on the outskirts of Athens and has established headquarters at Marathon, from which will radiate a health and home betterment service which will cover eight to twelve villages where malaria and other diseases have enervated the people where living conditions are deplorable.

IN 1929 the Near East Foundation decided to put on a five-year demonstration in the prevention and control of tuberculosis in the Greek city of Athens. This was pioneer work of a sort never before attempted in Greece—or in the Near East, for that matter—although tuberculosis is one of the major medical problems in that country. The results of this demonstration both as an educational and preventive service are evidence of the soundness of the techniques used; therefore, the methods of work may have interest for other public health nursing agencies in urban centers.

In order to understand the conditions under which the demonstration was set up, it is necessary to go back before 1929 and sketch very briefly the history of the refugee camps. Following the World War, the League of Nations undertook to carry out a great shifting of populations. According to the Lausanne Treaty in 1923 all the Greeks in Turkish territory, notably Asia Minor, were transported to Greece, and all the Turks were exported from Greece including Thessaly to the territory left under Turkish rule. In all, some two million people were torn up by the roots from the villages and towns where they had always lived and their people before them. Out of these, one hundred thousand were catapulted into Athens itself, which could barely sustain its own original population, and was burdened as all the Near East was, and is, with years of war debts. Agriculture, the principal occupation was backward and ineffectual, and trade had a heavy adverse balance. The population of Athens was thus increased by one-fourth. The newcomers were destitute of clothes, money, or other belongings and suffering from extreme mal-nutrition and diseases brought on through the privation which preceded and followed their transplanting.

The government of Greece welcomed these refugees, but it had no resources with which to alleviate their wretched condition, much less rehabilitate them economically. Churches, schools, empty warehouses, spare rooms in private homes, theatres, and street corners re-

ceived them. Large government barracks were turned over for housing, but by no stretch of the imagination could they be called homes then or now. These barracks were rough wooden sheds, containing no sanitary provisions or hygienic methods of ventilation. The people put up partitions to divide family from family and five and six people, sometimes ten to fourteen, slept and carried on their life in one small room, whose average size was ten by twelve feet.

CONDITIONS IN KAISARIANI

The camp of Kaisariani which contained one thousand three hundred and thirty-two families, with a population of five thousand one hundred and

Kaisariani Camp. Typical home, when Miss Carr started service

eighty-four, was chosen by the Near East Foundation as the center for the demonstration in tuberculosis control. Conditions in this camp were unhygienic in the extreme. The barracks were built in hollow squares and in the middle of each square was a large public latrine in bad repair and smelling atrociously, a home base for flies and mosquitoes. There were only eight of these public latrines for the use of the entire camp and no private ones at all. Garbage was taken up by city wagons and hauled away to be dumped in the country. Water was very scarce, being doled out at public taps certain hours of the day and when that ran short, being supplemented in the summer by water carts, around which the women crowded to receive their rations, poured into old Standard Oil Company tins; the housewives carried these unsterilized containers back to their crowded one-room shacks, and made the water go as far as possible. Markets where meats and other produce were sold were unprotected in any way from the sun, the dirt, swarms of flies, stray dogs, and unrestricted handling. There was no sewerage system. Small gutters cut in the dirt ran down the unpaved streets in front of the barracks.

It will be seen that any health service which was not to be merely a relief program, and therefore a permanent liability supported only by foreign aid, had to take these points into consideration, and was greatly handicapped from the start. The government could not support even a mildly expensive public health service, and the community certainly could not. Hospitalization was generally out of the question for two reasons—there were very few hospitals in Greece, and the expense made them prohibitive for these people. The problem, therefore, was to build up the health of the people, and educate them so they could keep on top of their enforced environment. In other words, the solution of the problem lay in so changing the habits and customs of the people that they would make a new environment for themselves in the midst of poverty and unchanging economic conditions.

LIFE IN THE CAMPS

As the habits and customs of the people were the pivot around which the demonstration was to revolve, it will be well to describe the average family pattern as it existed there and still exists in neighboring camps. The average mother in the community was found to be intelligent, willing to learn, but tradition-bound. She was superstitious and afraid of change, naturally, since change had played such a disastrous rôle in her life. The father, if there was one, worked when he could and spent the rest of the time in a dirty coffee house. A survey showed the following customs to be representative:

The Homes: No ventilation. Win-

dows and doors were shut tightly at night. Windows were never opened because of fear of cold. No heat except from small charcoal burners that threw off a carbon monoxide which often proved disastrous.

Vermin, such as bed bugs, roaches and flies, were unchecked.

Many of the rooms, where there was no rock to prohibit digging, had a small shallow cellar, three or four steps down under half the thin flooring; this hole was used as a store place and in rainy weather was apt to fill with water. As it was hard to empty, the people frequently let the water stay until it soaked up or dried up of its own accord.

All cooking was done in the streets, when the weather permitted, on small charcoal stoves (fou fou or mangol) more like the pans used by roasted chestnut vendors in this country. Charcoal, which costs about three to four drachmas a day (four cents), was used as sparingly as possible.

Dirty water and refuse were thrown into the street, and garbage tins were left uncovered.

Dishes were washed in cold water sprinkled with a few ashes from the charcoal pan. Soap was little known and expensive. Knives and forks were frequently cleaned by sticking them into the dirty soil.

Beds were unaired. Generally there was only one bed to a family. Anywhere from two to six people, sick or well, slept in one bed; the children spent the night on the floor on any rags or bedding available, huddled together for warmth.

Child care: All babies were swaddled after the manner of the East, so that they could not move their legs and arms for the first few months of their lives. Their beds were hammocks which produced humped backs and sunken chests. Older children were covered with layers of clothing and kept out of the sun.

Babies were frequently fed food chewed up first by the mothers.

Children were usually fed out of the mother's bowls and had no dishes of their own. This spread diseases from mother to child, *vice versa*, and to other children.

There were no regular hours for feeding or sleeping.

Children were bathed on an average of once or twice a winter by pouring a little water on them, or rubbing them with some soap and water, then rinsing them off—a kind of Turkish bath. Children and adults bathed a little more often in summer. Only the hands and face and sometimes the feet were washed regularly. Clothes were generally washed in water sprinkled with ashes from the charcoal pans.

Kaisariani Camp. A swaddled baby in a curved bed

Food: Bread, olives, cheese and cucumbers were the basic fare for the poorest in the camp. Those a little higher in the scale of living occasionally added stews of tomato paste, one green vegetable, beans or rice, and boiled onions to their diet of bread and olives. Potatoes, meat and peppers were eaten as seldom as once a month. Stews of lamb, onions and vegetables cooked in olive oil were the most sumptuous meals to be had and were reserved for fete days. Sometimes summer squashes and grape vine leaves were stuffed with rice and meat. When meat was to be had it was only the cheapest cut of mutton. Occasionally there was fish. When anything was cooked it was fried or stewed in olive oil or mutton fat, generally the latter. Cooking food was an expensive process because of the cost of charcoal. In the very poor families which constituted the large majority as little cooking as possible was done. Most of the vegetables came from gardens which

were fertilized with animal excreta; this together with dirty food, and filthy personal habits made enteric dysentery common, as well as summer diarrhea.

There was little fruit eaten as it was too expensive. Melons and cucumbers were common in the summer, but of course these had no nutritive value. Greens, milk, and pureed soups had no value in the eyes of the refugees. Such protective foods as eggs, milk and butter were prohibitive in price. Cheese was made from goat's milk and was very unsavory, while the bread was poor in quality. No difference was made between the diet of a child and an adult. Vegetables were not mashed but given whole to infants. Those who could afford it gave the children a cup of milk now and then but generally tea was given them instead. The monotony of the diet for all but a few is obvious. The preparation was bad.

Care of the sick: The sick were never isolated. Sick and well occupied the same bed. Children played on and around the bed of the mother who was ill of tuberculosis, a cold, or pneumonia. Neighbors crowded into the room and sat around and "entertained".

No special foods for invalids were prepared. The one common invalid food was yaghourt, a sour milk cheese, which was good for the intestines but dissolved calcium, thus breaking down any protection against tuberculosis.

No precaution was taken to prevent the spread of contagious diseases. The bathing of patients or disinfecting and ventilating their quarters was unusual.

The majority of mothers had native midwives in attendance at the births of their children. These women were old, dirty and untrained. Consequently there was considerable puerperal infection.

SUPERSTITIOUS PRACTICES AMONG THE REFUGEES

Spider webs or chewed tobacco were used to stop the bleeding of fresh wounds. Scrapings from shoes were applied to cuts. Abscesses and infections were given applications of sugar, or soap, dry figs, or onion tops heated until brown, or nettle leaves. For a dog bite, some of the dog's hair was applied to the bite. For a snake bite, the person giving the treatment took a charm and made an incantation over it until he yawned. When the yawn came the cure was effected, supposedly.

Hemorrhages were treated by drinking quantities of boiled tea.

Sore thoats were massaged on the inside by a finger (not necessarily a clean one). For earache, a very small or new born mouse was placed in a bottle of oil which was hung in the sun. When the mouse had wholly dissolved the oil was in the right condition. A few drops were warmed slightly and poured into the affected ear.

Rule for making a splint: goats hair, mixed with white of egg was placed on the affected part; when dry, it stayed in place. This made a fairly stiff splint.

When a person had an enlarged spleen, a large leaf of cactus was taken and an incantation for every thorn made over it. When the cactus dried, the spleen was supposed to be well.

PLANS FOR THE WORK

It was felt that if the demonstration was a success in Kaisariani, it could be copied successfully by other Greek urban groups. The interest of the government was enlisted, and its coöperation promised.

In 1929 fifty cases of tuberculosis were selected. To these patients Miss Alice Carr, working with the native Greek doctor, gave from October to April one tin of milk a week and three doses or soup-spoons of cod liver oil which amounted in all to one kilo of cod liver oil a season. The net cost of this distribution was thirty-six cents a month for milk per person, and seven and one-half cents a month per person for cod liver oil. Education was carried on in the clinic only; there were no home visits. After six months of this experimental treatment it was found that the patients gained decidedly in weight and had lower temperatures. There was no follow-up, however.

On the receipt of the record of this trial, a plan for a controlled demonstration was approved.

The first "well clinic" in Greece was opened in the camp across the street from the long line of barracks. This clinic was a small converted coffee house having a main room, in which classes were held, a doctor's examining room, a weighing and record room, and three small back rooms, used for the storage of cod liver oil, milk, and old clothes. Only bare necessities were available in the way of equipment.

A survey of one thousand homes was made in July, 1930, and each individual was examined by a Greek doctor. One out of every six persons was found to be infected. All the children were infected. Each person, whether child or adult, who was actually infected or who had relatives or close neighbors infected with tuberculosis, was put on the clinical list. This meant a group of one thousand individuals were carried for treatment of one sort or another. Almost all of them were undernourished. Outside of milk, cod liver oil, and ultraviolet ray treatment no medication was given by the Near East Foundation staff. The people filled their prescriptions from their own funds or went without.

For the person living on the lowest rungs of the economic ladder, there was no free treatment available. He simply went on carrying the infection which increased in him, ignorant of health rules and a menace nationally and internationally, especially since most of the people living on a very subnormal subsistence level in Kaisariani were servants in hotels and homes, in other words, handlers of food.

ATTACKING THE HOME SITUATION

The attack on the problem, therefore, had to be in the home itself. There were no relief agencies, and no relief funds on which to draw. The patient had to lift himself up by his own boot straps. The Near East Foundation was the only organization sufficiently interested and well-informed that could show him how. Dirt, squalor, malnutrition, ignorance, and fear were the enemies which had to be overcome. Side issues of the demonstration were the prevention of epidemics and intestinal parasites which depleted the people and led to tuberculosis.

One nurse visited each family on the list at least three times a month. There she checked up the living practices moment by moment, and saw whether or not the women carried out the advice given them at the clinic. She gave individual advice in home nursing, bathing, preparation of food, and sanitation. Her findings were discussed with the patient at the clinic when she came in for examination.

The most important part of the demonstration was the institution of daily educational classes. The American Red Cross gave permission to the Foundation to have its text book in "Home Hygiene and Care of the Sick" translated into Greek. The classes started with thirty-five women. It increased each month until at the close of the session in August one thousand women were attending regularly once a week in classes of sixty to seventy. In their eyes these classes came next to their families in importance; many of the women coming to the classes every day. At these classes, the women saw the nurse handle a real baby properly, volunteered to become patients in the demonstration bed, and learned with their own hands how to perform the necessary duties in home nursing.

[What happened as the result of this work will be described in April]

The Diabetic School Child

By MARY E. TANGNEY
Allston, Massachusetts

LO, the modern diabetic school child! There is a healthy glow in his eye, animation and self-confidence in his stride, and a ruddy look of well-being in his appearance. The medical world must justifiably feel the joy of achievement in such an accomplishment. It is true, this child carries his diabetes through life but it is not the woeful burden one might think, because youth accepts and adjusts itself to the unusual more quickly than does age. In his early years, the diabetic child is taught the qualifications of a health maintaining diet, the advantages of physical exercise and rest, and the necessity of preparing himself for the future. Unlike the average child, he is not expected to have them "swim into his ken" at the end of adolescence. They have been constituting his background for many years.

A diabetic school child of the insulin era is usually as tall as the normal child and quite frequently he is taller. His weight may be less than that stated in some standards, but the importance of inheritance must be kept in mind. He is more susceptible to tuberculosis and other infections than is his normal playmate, and the "common cold" if neglected may lead to severe acidosis or coma.

It is a proved and accepted fact that the diabetic child is mentally precocious, and, as a rule, has no difficulty with his studies.

Broadly speaking, the total day's calories in his diet should not be more than 33 to 50 per cent more than the individual's requirement as determined by the theoretic metabolism. Overweight is to be avoided as it is coexistent with severer diabetes. As the child grows older his caloric requirements increase up to adult life, and then gradually drop; and of necessity the insulin must usually be increased to accommodate the additional diet which is necessary for normal growth and development.

A TYPICAL DAY WITH A DIABETIC CHILD

Let us start the day with a fourteen-year-old child in his freshman class at high school. He is a diabetic of three years' duration. His day starts at 7:30 A.M., when he has a pre-breakfast dose of insulin*. On arising, a specimen of urine is tested. If he has a mild case of diabetes, this specimen will be sugar-free without a bedtime dose of insulin. But our patient is of a more severe type and takes four units of insulin at bedtime, so that on arising, he will have a store of glycogen in his liver which would otherwise be lost as sugar in the urine.

At 8 A.M. breakfast is ready. The diet is as follows:

Oatmeal	15 grams (120 grams if weighed when cooked)
Bread	30 grams (Weigh as bread, then toast)
Butter	10 grams
20% cream	30 grams
Egg	1
Grapefruit	100 grams

Before 9 o'clock the child is at school. The first three periods are concluded by 11:15 A.M. These are, respectively, mathematics, Latin, and English. His grades in these subjects are excellent, but he is particularly enthusiastic about English, which is studied in the third period. The energy spent in wholehearted participation of class discussions, together with the excitement which goes with competitive individual recitations and projects covered in this

*Patients and parents both are taught to give insulin and to carry out simple sugar tests of urine.

subject, burn more calories in such a pupil than they would in a less ardent one. The natural outcome of such a procedure is a gradual lowering of the blood-sugar. In the beginning of the school year, this boy has found that his fourth period was the most difficult. His grade in this subject is decidedly lower than the excellent ones received in the other studies. He finds it difficult to concentrate on the class work, and his teacher reports that the child is inclined to slump in his seat, and appears sleepy and tired. Insulin reactions are very apt to take place at this time, and especially in this boy who has used up many calories through sheer excitement in the previous period. This child is showing early symptoms of an impending hypoglycemia. To correct this condition, ten extra grams of carbohydrate are given daily at 10:30 A.M. with excellent results.

About five minutes before the child actually sits down to eat his luncheon, he takes four units of insulin. At first this may seem an untimely procedure when it has just been stated that he has had ten grams of carbohydrate at 10:30 to prevent an unwarranted lowering of the blood-sugar, but if this noon dose is omitted, experience proves that a specimen of urine collected at 4:00 P.M. contains enough sugar to give a yellow reaction when the Benedict test is employed.

Insulin is carried to school in a traveling kit. It consists of a leather case which contains a hypodermic syringe and needle continually kept in alcohol in one compartment, a swab, also in alcohol, in another compartment, a vial of insulin, and two reserve needles. This case, a very compact one, measures 6½ inches long and 2½ inches wide. If the dose is five units or less, the usual rule is to use U-20 insulin; if it is twenty-six units or more, use U-80 insulin; for all other doses, use U-40.

If the luncheon is carried it may be as follows:

Bread	45 grams (White or dark)
Ham	60 grams (Minced or sliced)
Butter	10 grams
Apple	100 grams
Milk	240 grams (The half-pint jars may be bought, or if a hot drink is desired, the milk may be flavored with one teaspoonful of ovaltine and carried in a thermos jar.)

The fifth period is for study, and the last is used for choral practice, hygiene, or military drill. These hours are uneventful.

HOW DO DIABETIC CHILDREN RANK

Recently, schools were visited where three diabetic children were studying. Doris is a pupil in grade IX. She was an honor student in grades VII and VIII of the same junior high school. Doris takes 15 grams of carbohydrate in the form of fruit at 10:30 A.M. It is interesting to notice that the subject in which she does most poorly is ancient history, which is scheduled for the period immediately before luncheon three times a week, and during the last period for the remaining days. Doris is particularly sensitive about her diabetes, and rather than have most of the children in her class know about it, she takes two units at 3:00 P.M. and none before her luncheon. It seems to work well in her case. She lost eight sessions in the September-October term, and none in November or December.

At the high school where the other girls were studying, it was more difficult to obtain information because permission could not be obtained to see the records. However, the principal stated that one girl was on the honor roll, and the other was passing well in all subjects. The honor student had a high normal I.Q. and the other a superior one. Neither girl has lost a session in the September-December term. In none of these three instances were special privileges allowed the girls.

NORMAL ACTIVITIES AT HOME

After school it is wise for a diabetic child to have his own duties as do the other children in the family. Otherwise he may think of himself as a semi-invalid, and this idea is just the one to be avoided. His parents should not bring the subject up constantly, nor should they consider it their duty to ex-

plain his condition to their friends in his presence. He should be spared this, especially at the adolescent age when all children are inclined to be sensitive. The diabetic child will confide his story to those who he feels have a sincere interest in him. By no means should he be ashamed of his diabetes. Rather in a tactful way, it should be stressed that he is indeed fortunate to know so much more about healthy living than does the average layman, and that his doctor thinks of him as a very intelligent, trustworthy person who, by using his good brain, can live a longer than normal life and enter any profession to which he feels himself fitted.

Exercise in the open air is a necessity for any child who has been pent up in a class room since early morning. The diabetic child, who usually likes to read and study, must learn to enjoy physical exercise. Girl and Boy Scout activities are excellent because they develop morale, and because they interest the child in field and forest. In exercise as in all other things there should be no extremes, because too much like too little will cause the reappearance of sugar in the urine.

The next feature on his program is dinner. The child should be able to prepare his own meals, but he should not have to do it too often, as food one prepares oneself is never so appealing. Also, the weighing of the diet may become tiresome to the adolescent who faces the regime for many years to come, and be tempted to follow a dietless life. However, he should be encouraged to develop all interest in regard to his diet so that he will not be left stranded in case of the unexpected. One should not hesitate to congratulate him for keeping to his diet. It is not always easy. Nor should the parents after a period become so accustomed to him as to forget that this diabetic child is a splendid little person who may sometimes grow discouraged. They should never let him lose sight of the fact that medical research is constantly looking for a more complete aid than insulin.

The early evening dose of insulin should be given twenty to thirty minutes before the evening meal. Dinner on school days should be bulky because the luncheon is so often concentrated. It should provide one or two vegetables beside potato. An average dinner would be as follows:

Meat	90 grams
Spinach	150 grams
Peas	75 grams
Potato	120 grams
Butter	10 grams
Milk	120 grams
Orange	150 grams
Bread	30 grams

A typical total day's diet then is as follows:*

Food	*Grams*	*Carb.*	*Protein*	*Fat*
Milk	540	27	18	18
Oatmeal	15	10	3	1
Bread	105	63	11	0
20% Cream	30	1	1	6
Egg	1	0	6	6
Meat	150	0	40	25
Butter	30	0	0	25
Orange	400	40	0	0
5% Vegetable	150	5	3	0
10% Vegetable	75	5	2	0
Potato	120	24	3	0
Grapefruit	100	5	0	0
		180	88	81

(180 x 4) 720 Calories	Total carbohydrates	180
(88 x 4) 352 Calories	Total protein	88
(81 x 9) 729 Calories	Total fats	81
1801 Calories	Total Calories	1801

Bedtime should be no later than 9:30 P.M. When possible it is well worth while to test another specimen of urine at this time. When a late evening dose of insulin is prescribed, it is best given at the parent's bedtime.

WHAT PARENTS SHOULD KNOW

In conclusion, it may be interesting to say that in some cities and towns the general practitioner who may be treating several adult diabetics will find himself unable to cope with the diabetic child in an emergency. For this reason it is always wise for the parents to be instructed by the physician in possible conditions arising from diabetes. It is

*Naturally all of the typical diets given in this article—the amounts and kinds—would be subject to the attending physician's approval and suited to each individual's need.

really not a difficult thing to distinguish between insulin shock and diabetic coma, but coma is so insidious in its onset that one would be apt to think it was a gastric upset which develops and disappears quickly in the normal child. Insulin shock comes on comparatively suddenly and the child is in a state of profound unconsciousness. But coma from acidosis occurs at the end of a long trail of symptoms, usually covering a period of hours. The attack most frequently starts with nausea and vomiting. There may be chills and the patient becomes sleepy. There is often severe abdominal pain which is sometimes confused with acute appendicitis, sweetish odor to the breath, labored respiration, and finally a coma which is not usually so profound as that of insulin shock. The skin is dry.

Acidosis comes from one of the following reasons:

Breaking of dietary regulations
Omission of insulin
Prolonged starvation
Infection

When the diabetic child is not well he should be put in bed, the physician notified at once, and his hourly specimen of urine examined until he is definitely under control. Even if he does not eat, or is not retaining his food, he should be given some insulin. If there is no doctor available and the urine specimen is red or orange, 15 units of insulin should be given; if yellow, 10 units; if yellow-green, 5 units. The urine should be tested every hour with the insulin dosage depending on whether or not sugar is present. Parents are instructed to do this at once without the physician's presence, since every minute counts.

Sometimes the child says he feels "reactionish," and certainly looks it. Yet when the urine is examined, it will be found to have a large amount of sugar. Upon being questioned the child will usually say he has not voided for three or four hours. This means that he may have had a high blood-sugar at an earlier period, but perhaps due to some good vigorous exercise or intense excitement, the blood sugar may have fallen incredibly in the last hour. In such an event a second specimen of urine voided immediately after the first will usually be sugar-free, because it is no longer contaminated by urine which has been formed during a hyperglycemic period and which has been allowed to remain in the bladder. If the symptoms (nervousness, hunger, trembling, perspiration, double vision) are not recognized and treated, the patient loses consciousness. Then the procedure is as follows: Notify the physician; give one-half ampoule or about 0.5 c.c. of adrenalin (1-1000) under the skin.* Corn syrup may then be given by teaspoon. This treatment is usually effective and may be carried out easily at home.

According to Dr. Joslin's records, there are now at this present date (December, 1934) the total number of 186 living patients who developed diabetes in childhood and who have lived ten years or more. It certainly is our good fortune to see these growing diabetic children poised, alert, self-confident, able to say in the words of Walt Whitman:

"Afoot and light-hearted, I take to the open road;
Healthy, free, the world before me,
The long brown path before me, leading wherever I choose."

*The physician has prepared the parents for such emergencies.

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"Diabetic Manual," Elliott P. Joslin. Philadelphia, Lea & Febiger. 1934. $2.00.

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, Inc.

Edited by KATHARINE TUCKER

REPORT OF THE JANUARY BOARD MEETINGS

The N.O.P.H.N. Board reviewed the major events—actual and prospective—that may have a profound effect on public health nursing. It was felt that, with the various proposals growing out of the President's Committee on Economic Security and the probability of greatly increased Federal appropriations which will bring about the extension of public health and public health nursing activities, there is exceptional need for the N.O.P.H.N. to participate in national planning. Its knowledge of the activities of and need for public health nursing throughout the country and its nationally developed and accepted standards are sought and being put at the disposal of those departments and bureaus in the Federal Government which will have the responsibility for appropriating the money to the best advantage for the nation's health.

Careful consideration was given to the 1935 program of the N.O.P.H.N. itself, both in the light of its reasonably assured income and also the most needed points of emphasis—as fast as further income is available. It was assumed that certain activities must continue so long as there is an N.O.P.H.N.: statistical studies that will answer the most important questions as to what actually is happening to public health nursing today—in administration, in service, in finance, in relationships; the continual revision and promotion of standards; the activities of committees which serve as the background for these standards and for the development of new policies; publications which are the basic literature in the public health nursing field—monthly magazine, reprints, books, and promotional leaflets; organizational activities such as membership work and assistance to state groups. With all social planning in such an experimental state, it is essential that the N.O.P.H.N. should represent public health nursing wherever national planning is taking place.

Assuming that these activities are the very foundation upon which a national organization is built, the next question is to what extent a limited budget allows also for all of the direct service demands that come to its door. Letters, hundreds of them, coming in every day from all over the country must be answered; those who come into the office to talk over their problems and "get the latest" as to what is happening must be seen—all of this must be done whatever the size of the staff. But the Board and staff gave equally serious consideration to the requests and the need for more field service. To respond to this takes more time and more money—two exceedingly scarce commodities these days, and particularly with the N.O.P.H.N. However, neither the Board nor the staff is daunted and, therefore, they are going to try to develop a type of field service that will reach the greatest number of people for the least expenditure of money. Plans are now under way to work out some type of regional group conferences in various parts of the country which will afford an opportunity for public health nurses carrying various kinds of responsibilities or representing special interests to get together to discuss their problems with an N.O.P.H.N. staff member acting as discussion leader. Further report of this plan will have to await later developments, but this suggestion coming from the staff was approved by the Board. In other words, the N.O.P.H.N. is constantly seeking the most effective way of making your dollars serve you and public health nursing.

Speaking of dollars, the report below gives the figures for 1934 income and expense.

N.O.P.H.N. INCOME AND EXPENSE
1934

Income	
Membership dues, individual	$21,372.00
Membership dues, corporate	15,617.04
Contributions	28,429.65
*Magazine	17,742.03
Reimbursements	2,691.59
Convention	4,003.69
Miscellaneous	3,504.91
Total Income	**$93,360.91**
Expense	
General Administration	$ 8,464.94
General Operation (includes accounting, extension, membership)	17,579.41
Advisory and Consultation Service	31,355.20
*Publications and Educational Service	27,398.74
Studies and Research	4,478.83
National Planning	2,000.00
Total Expense	**$91,277.12**
Summary	
Expense	$91,277.12
Income	93,360.91
Balance	**$ 2,083.79**

*PUBLIC HEALTH NURSING MAGAZINE

Income	1934
Subscriptions	$13,066.22
Advertising	4,675.81
Total Income	$17,742.03
Expense (allocated)	
General Administration	$13,744.95
Travel	136.86
Printing	7,761.84
Subscription Promotion	500.00
Total Expense	$22,143.65
Summary for Magazine	
Expense	$22,143.65
Income	17,742.03
Deficit	$ 4,401.62

You will see that we are able joyously to report that we actually closed the year with a small balance instead of a large deficit as we feared. This glorious fact is due chiefly to two reasons: the unexpected renewal of one of our larger contributions and the splendid way in which our individual membership has stood by us so that it exceeded the total for 1933. Never was a balance more needed to be carried into any year than into 1935 because of our known losses in income which have already been reported. Not only do we need everyone to continue to stand by but also you know all too well that we are seeking and must seek new sources of income from individual memberships, corporate memberships, and contributions—not to mention subscriptions to the magazine—in order to continue even on the reduced budget of 1934.

A NEW STAFF MEMBER

However, the Board felt that the special generous gift from the Commonwealth Fund presented a real obligation in spite of the deficit in general income and expense which we face for 1935. Therefore, it authorized the addition of a member to the staff and it is with the greatest of pleasure that we announce that Ruth Houlton, formerly general director of the Minneapolis Visiting Nurse Association and previous to that state supervising nurse of the Minnesota Department of Health, is coming to the staff in March. We are most fortunate in having someone who brings so much in herself and in her exceptional background of experience in public health nursing with an outstanding private agency, an exceptional official and state public health service, and as acting director for one year of the public health nursing course at the University of Minnesota.

The report of the Joint Vocational Service may be found below.

By vote of the Board it was recommended to the joint boards that the N.O.P.H.N. Committee on Community Nursing Service be made a joint committee, inasmuch as the interests of the committee were involving all fields—hospitals, private duty, and registries. The joint boards agreed to this change. The personnel of this committee, already representative of the various fields of nursing, remains the same.

The appointment of Marie T. Phelan, Olivia T. Peterson, and Mrs. Elizabeth Soule as N.O.P.H.N. representatives to the National Committee on Red Cross Nursing Service was ratified.

REPORT OF JOINT VOCATIONAL SERVICE

On December 31, 1934, 1,956 candidates were actively registered with the Joint Vocational Service—524 for public health nursing positions, 1,432 for social work. There were 1,493 positions listed on this same date, 95 in public health nursing.

The present situation might be described as one of under-employment rather than of unemployment. Nurses are stating more definitely what kind of opportunities they will consider and their feeling of greater security is evidenced by less flexibility in their preferences. There is much pressure for permanent placement from nurses in temporary emergency positions and for better salaried positions from those grown weary of trying to adjust to unsatisfactory working conditions. There is a seasonal shortage of exceptionally good material, especially for supervisory openings, while residential requirements are still a problem to J.V.S.

Miss Tittman has recently addressed the students in a high school, the undergraduates in a school of nursing, the students in a special unit course at Teachers College, and a group of the Educational Section of the Virginia State Nurses' Association. Plans are being made to address the Vermont State Nurses' Association and to interview the Simmons College students this spring.

The total volume of work in 1934 increased thirty-three and one-third per cent over 1933 and with the demands of the newly created positions in the rural health field, will probably keep up this record in 1935.

Through economies, J.V.S. closed the year without a deficit.

LILLIAN A. QUINN,
Executive Director.

The following are among the placements which Joint Vocational Service made or has heard of that will be of interest:

Amelia Meyersieck, as Generalized Supervisor, Visiting Nurse Association, Hartford, Conn.

Mrs. Katherine Miller, Philadelphia, as Assistant to the General Secretary, Pennsylvania State Nurses' Association, Harrisburg, Pa.

Augusta Mueller, as Assistant District Supervising Nurse, New York State Department of Health, Albany, New York.

Eleanor W. Platt, as Nurse-Social Director, Willard Parker Hospital, New York City.

Helen C. Peck, formerly Director Infant Welfare Society, Minneapolis, as Chief Consultant in Public Health Nursing, State Department of Health, Boston, Mass.

Catherine Corley, formerly Alabama State Department of Health, as Assistant Supervising Nurse, Eastern Health Unit, Baltimore, Maryland.

Madge M. Jones, formerly Superintendent of Visiting Nurse Association, East St. Louis, Illinois, as Supervising Nurse, American Red Cross, Perth Amboy, New Jersey.

Margaret Blee, as Generalized Supervisor, Visiting Nurse Association, Denver, Colorado.

Florence Stein, as Advisory Nurse, State Board of Health, Louisville, Kentucky.

Irma Fortune, as Nursing Field Representative, American Red Cross, Washington, D. C.

Kiddie Howard, as Supervising Nurse, Norris Dam District, State Department of Public Health, Nashville, Tenn.

Cecilia A. Evans as Director, Visiting Nurse Association, Lincoln, Nebraska.

Sadie Gladwin, as Educational Supervisor, Visiting Nurse Association, Springfield, Mass.

Florence McConnell, as Supervisor, Public Health Nursing Association, Schenectady, N. Y.

Mrs. Josephine W. Prescott, as Instructor in Public Health Nursing, Department of Nursing Education, Teachers College, Columbia University, New York City.

ROLLING UP THE HONOR ROLL

The most tangible honor the N.O.P.H.N. can give is for membership! When Miss Mary S. Gardner led our membership enrollment in 1932, the custom was started of awarding a certificate of honor annually to each local agency whose staff was enrolled 100 per cent in the N.O.P.H.N. Thus was given an "outward and visible sign" of the loyalty of individual nurses to their own local agency and to their National as expressed through membership.

Who have won the honors? One-nurse agencies, health department staffs, school nurse groups, nurses in industry, Red Cross chapters, insurance nurses, visiting nurse associations—large and small, near and far have coöperated with their State Membership Representatives to win this award.

It is natural that New York State, having the largest number of local agencies, should win the largest number of certificates of honor in 1932 and 1933. But Rhode Island, the smallest state in the Union, plunged ahead to first place in 1934.

States having second place for number of agencies on the Honor Roll were Arkansas in 1932, Pennsylvania in 1933, and Massachusetts in 1934. Where will your state be in 1935? Remember to notify the N.O.P.H.N. when all of your staff is enrolled, as we get this information only through you. Write in for your certificate of honor, frame it and hang it on the walls of your headquarters' office. It is noticed by visitors from other agencies and other cities; it is a cheerful greeting to N.O.P.H.N. staff members on their travels; it is one tangible evidence that through membership the individual nurse, the local agency and the National Organization are all linked together for better service throughout the length and breadth of our country.

The first report of the 1935 Honor Roll of organizations carrying 100 per cent staff nurse membership in the N.O.P.H.N.:

COLORADO

***Colorado Tuberculosis Association, Denver
**Metropolitan Life Insurance Nursing Service, Denver
****Visiting Nurse Association, Denver

CONNECTICUT

***Visiting Nurse Association, Stamford

GEORGIA

****Metropolitan Life Insurance Nursing Service, Atlanta
***Chatham County Health Department, Savannah

ILLINOIS

****Hourly Nursing Service, First District, Illinois State Nurses Association, Chicago
****Board of Education, Galesburg
*Metropolitan Life Insurance Nursing Service, Harvey

INDIANA

*Red Cross Public Health Nursing Service, Fort Wayne
***Visiting Nurse League, Fort Wayne
*Visiting Nurse Association, Muncie
****Public Health Nursing Association, Richmond

IOWA

****Public Health Nursing Association, Muscatine
**Visiting Nursing Association, Waterloo

KANSAS

****Public Health Nursing Association, Topeka

MAINE

***South Franklin County Nursing Service, Wilton

MASSACHUSETTS

*Visiting Nurse Association, Cambridge
*Emergency Nursing Association, Dedham
****Visiting Nursing Association, Fitchburg
***Visiting Nurse Association, Lowell
**Metropolitan Life Insurance Nursing Service, Malden
****Newton District Nursing Association, Newtonville
****District Nursing Association, Watertown

MICHIGAN

**Visiting Nurse Association, Dearborn

MINNESOTA

****St. Paul Baby Welfare Association

MISSISSIPPI

**Lauderdale County Health Department, Meridian

*Asterisks indicate number of years organization has held 100 per cent staff nurse membership. The Honor Roll has been in existence four years.

MISSOURI

***St. Joseph Organization for Public Health Nursing, St. Joseph

NEW HAMPSHIRE

****Good Cheer Society, Nashua

NEW JERSEY

****Visiting Nurse Association, Bayonne
*Visiting Nurse Association, Moorestown

NEW YORK

***Cayuga County Committee on Tuberculosis and Public Health, Auburn
****North Shore Public Health Nursing Association, Flushing
****Joint Vocational Service, New York City
****National Organization for Public Health Nursing, New York City
****Metropolitan Life Insurance Nursing Service, Plattsburg
****Dutchess County Health Association, Poughkeepsie

OHIO

*Visiting Nurse Association, Lima
**District Nurse Association, Toledo

OKLAHOMA

****Public Health Association, Tulsa

OREGON

***Oregon Tuberculosis Association, Portland

PENNSYLVANIA

**Palmerton School District, Palmerton
****Service Circle of the King's Daughters, Pottsville

RHODE ISLAND

***Visiting Nurse Association, Barrington
****Visiting Nurse Association, Cranston
****Smithfield Public Health League, Esmond
****District Nursing Association, Providence

TENNESSEE

*Sumner County Health Unit, Gallatin
***Metropolitan Life Insurance Nursing Service, Memphis
***Metropolitan Life Insurance Nursing Service, Nashville

VIRGINIA

*Fairfax County Health Unit, Fairfax
*Prince Edward County Health Department, Farmville

WASHINGTON

***Metropolitan Life Insurance Nursing Service, Tacoma

WEST VIRGINIA

**Wheeling Chapter, American Red Cross, Wheeling

HAWAII

*Palama Settlement, Honolulu

Inquiries have been reaching us concerning "The Nurse's Part in Medical Care," Miss Tucker's most recent radio speech. The N.O.P.H.N. does not sell it. The speech is available in pamphlet form from the University of Chicago Press for fifteen cents; lower prices on quantities of ten or more. The entire series of nineteen lectures, of which this speech is one, is called Medical Economics, and may be secured for $2.00. Address: University of Chicago Press, 5750 Ellis Avenue, Chicago, Ill.

Ohio has presented two of her nurses with life membership in the N.O.P.H.N. —Elizabeth M. Folckemer, Director of the Cleveland Visiting Nurse Association, and Cora M. Templeton, Superintendent of Nurses of the Cleveland City Board of Health.

BOARD MEMBERS PAGE

Edited by KATHARINE BIGGS MCKINNEY

ANOTHER SUCCESSFUL ANNUAL MEETING

The Chairman of the Bureau of Promotion of the Public Health Nursing Association in Indianapolis, Indiana, sends us this account of a successful annual meeting and a brief report on other activities of the Bureau. As the projects are planned and carried out coöperatively by the board and staff, they form a happy, natural chance for better acquaintance and understanding of each other's functions:

"The annual meeting of the Public Health Nursing Association of Indianapolis was held in January as a luncheon meeting and was unanimously voted a success. This was particularly gratifying since the entertainment for the meeting, as well as all the other publicity for the past year, has been undertaken as a group publicity project.

Recognizing the direct, emotional appeal of brief playlets depicting some actual phase of the field work, we have presented two and hope to perfect a 'Play Portfolio,' based on actual cases for the purpose of further publicity. The nursing staff from time to time in round table conferences with the Chairman of Promotion, has brought numerous case-reports from which we have made a composite picture of the work.

For the Indiana State Fair the Public Health Nursing Association presented a playlet on 'Contagious Diseases' as a propaganda project, written and acted by the nurses on our staff. It was received with enthusiasm.

The entertainment for the annual meeting included a song, 'Here Comes the Nurse,' the words written by one of the nurses, and sung to the music of 'Here Comes the Sun,' the March of the Nurses, and a short skit—'A Round Table Conference.'

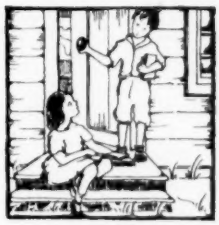
After the 'March of the Nurses' to the stage, one of the staff stepped forward and gave a pantomime bag demonstration. Then the coöperatively-written skit was presented by five nurses and a supervisor, depicting a round table conference at which three cases were discussed by the group: a chronic case, an aged grandmother, and a colored maternity case. The skit was natural and spontaneous.

Thirty of the active nursing staff were present at the luncheon and were seated at a long table at the end of the dining room opposite the stage. Their dark blue uniformed figures at the long table effectively fulfilled their designed mission, as did their march to the stage, giving to the Board and members of P.H.N.A. a tangible sense of numbers, an appreciation of their value and importance as a part of the community's social service and a thrill at really seeing those who carry the torch of health into hundreds of homes in our city under the slogan: 'A Nursing Service For Every Home. For Those Who Can Pay—For Those Who Cannot Pay.'

As a Board member I have found this group work of actual contact with the nurses and their field work of inestimable value in gaining a comprehensive view of the work of the Association. Too often Board work becomes theoretical, placid, utterly devoid of spirit, and we miss the spirit of those 'Girls in Blue' which breathes into the entire organization its life and purpose."

MARIETTE FINLEY HAHN,
Chairman of Bureau of Promotion.

The Providence District Nursing Association (R. I.) also held an annual meeting recently and celebrated its thirty-fifth birthday. It was a dinner meeting attended by 177 people and was followed by historical tableaux closing with the present staff of seventy. An address by Miss Mary S. Gardner, honorary director of the organization, and by Mr. Thomas Appleget of the Rockefeller Foundation followed.

SCHOOL  HEALTH

MODERN ELSIE SERIES, NO. V

MISS CARLING, WILL YOU GIVE A TALK ON SEX EDUCATION?

"Miss Carling, will you give my class a talk on sex education?" This came as a surprise from the junior high school principal, Miss Smith. Though Miss Carling admired the cold dignity and the intellectual ability of Miss Smith, she had thought her rather oblivious of the vital interests of the boys and girls who were rigidly "good" in her classes.

"Why are you asking for this, Miss Smith?"

"This year there are quite a group of girls and boys in the seventh and eighth grades who are acting silly. They write notes to each other and spend so much of their time in silly daydreaming. The other day I found such a vulgar note that I thought something ought to be done about it. I did call some of the girls who were implicated into my office to show them the error of their ways. It didn't seem to help much. It worries me, too, for some of these people were good students and their work is beginning to be affected."

"What did you tell them?"

"I tried to make them feel ashamed of such horrid thoughts as were expressed in the note. I tried to appeal to their honor, but I couldn't seem to do it. I've read that pupils of this age should receive scientific information instead of the erroneous misinformation which was indicated by the note. I know you are equipped by your training to give this."

"Frankly, Miss Smith, I think that the problem cannot be solved by a talk, nor would a talk be desirable. The pupils are in different stages of development; their preparation for the talk also varies. What might be helpful to some would arouse wrong emotional reactions in others. The difficulty is much more involved than lack of scientific information."

"What is involved?"

"In the first place I think that we, you as teacher and I as nurse, should be sure that we understand and have a frank, normal attitude towards sex and social hygiene. We cannot compare our experiences at this age with the experiences of these boys and girls, for their environment is so different from what ours was. Our attitude was that of taboos and inhibitions; theirs is not. Personally, I have received considerable aid in my thinking about social hygiene and the school program from the 1932 Yearbook of the Department of Superintendence and from the White House Conference Report, 'The School Health Program.' But going back to boys and girls and to our immediate problem, I think we must first remember that children of this age are developing very rapidly, both physically and emotionally. The girls are more mature than the boys. The vulgarity which was expressed in the note is much more vulgar in its meaning to you than it is to the child who wrote it and the children who read it. In the first place the thoughts originated, no doubt, from some adult source, either directly or indirectly. I think, usually, it's better to ignore the note, and to approach the problem more impersonally. Boys and girls are naturally very curious about these changes which are taking place in themselves and in their comrades. They are influenced by emotions which are perfectly natural, but new to them and because of

this newness not always wisely directed. I've often been concerned about how we were helping to satisfy this curiosity and whether or not we were offering opportunities for directing these new physical and emotional forces."

"We have our biology and general science courses which give information concerning reproduction."

"Yes, we also have a course in Home Hygiene and Care of the Sick for girls in the ninth grade which is good, but it doesn't reach all pupils and these not until they are in the ninth grade. But this information is so meager, so unrelated to the child's immediate problems. Can he possibly apply this information to his daily living? The physiology of reproduction, as such, does not answer the child's social and emotional needs. As someone has said, 'More attention should be given to the psychological factors of attitudes, feelings, habits, appreciations, and enjoyments, and to the sociological factors of personal relations and group standards; relatively less concern should be accorded physiological elements.'"

"That may be. But haven't you any practical suggestions to make since the talk is not indicated?"

"I think I have offered the most fundamental suggestions, which is to understand and to develop right attitudes ourselves. In addition I am thinking of two very practical things to do. First, our Parent-Teacher Association meets in two weeks. They have already asked me to give a health talk. We can't do very much about this alone and the help which parents can give is essential. I have some copies of radio addresses given by Newell Edson of the American Social Hygiene Association* which are entitled, respectively, 'Character Aspects of Education for Parenthood,' 'Mistakes We Parents Make,' and 'Training Youth for Parenthood,' which I think would give me excellent material upon which to base my talk. Then I wonder if we couldn't get together a loan library for parents, assisted by Mrs. Gooth, our Parent-Teacher program chairman. And, too, I have some copies of last year's *Hygeia* in which are some excellent articles on social hygiene. Some of these I would like to put on the library shelves for junior high school pupils to read as they desire, and I can write to the National Organization for Public Health Nursing, too, for material for both pupils and parents."

"Then you suggest that the information be given informally, that is, make it available for them to read if they wish, but not assigning it to them. That seems a good suggestion. What is the other practical suggestion you have in mind?"

"The second thing which I think we ought to do is to provide both school and community activities for these boys and girls. Since music and physical education have been eliminated from the school program during the depression, the only clubs which we have are the literary clubs. We have no activities in school which demand the development of physical skill for junior high school pupils. Seems to me our gymnasium should be open all the time after school and in the evenings, with someone there to direct activities, not only for pupils but for their parents as well. Outside school also, there are no facilities in town for recreation. For example, I like to skate, and since I've been here there isn't any place to skate unless you go two miles to the creek. Saturday I was skating on the creek and happened to see two of your ringleaders doing some excellent stunts on their skates. I wish we could have some winter sports within the community which many could enjoy. With Christmas coming and the cold weather accompanied by snow and ice, as it usually is, couldn't sports be developed?"

"I wonder. The Men's Club has already asked me if they couldn't do something for Christmas for poor boys and girls. Instead of food and clothing, I think we might suggest recreation to Mr. Gunn. He might be able to get some ERA workers to make a rink. He is an officer in the club so that what he

*50 West 50th Street, New York, N. Y.

says has some weight. They might open up a skating rink and, in addition, sponsor some winter sports.* Oh, yes, and Jack Osler has been here all year unable to get a position. He graduated from the physical education course at Teachers College. Maybe there is some way of giving him work and of directing recreation at the same time."

"Do you suppose the parents themselves could be interested in participating?"

"I don't know, but let us go and talk it over with our superintendent, Mr. Gunn. This is certainly a real problem. Since we have some definite suggestions for solving it, we may be able to initiate an active worth-while program."

*Information may be secured from National Recreation Association, 315 Fourth Avenue, New York, N. Y.

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Publication No. 626, Farm Boy to Man
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Publication No. 576, Biology in the Elementary Schools and Its Contribution to Sex Education
Publication No. 426, The Teacher and Sex Education
Publication No. 660, Progress in Sex Education
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Miss Carling's answer to this question has been compiled by Mellie Palmer, Supervisor of Health Education and School Nursing, Des Moines, Iowa.

? ? ? Question Box ? ? ?

QUESTION:

I am a public health nurse and have had experience on a Visiting Nurse Association staff. I am a high school graduate. I want to prepare myself for the field of social hygiene. What should I do?

ANSWER:

The American Social Hygiene Association suggests that the most practical and satisfactory plan for the public health nurse interested in preparing herself for this field is to spend a period of one or two months in study under its direct supervision. This period of study is employed in directed reading in the office of the Association (50 West 50th Street, New York, N. Y.) in conferences with staff members, and especially in observations and conferences in clinics and health departments and other public agencies where high-grade work is being done. This procedure has been eminently satisfactory in training health officers, medical social workers as well as public health nurses.

The second best arrangement would be for the nurse to follow a course of reading and at the same time work as an "apprentice" in a well developed public health nursing service which has suitable relations with clinics caring for various types of cases of syphilis and gonorrhea. The A.S.H.A. can assist in planning for such an arrangement.

A less satisfactory but still helpful method is to follow special courses of reading. The directing of such reading courses is a service that the A.S.H.A. and N.O.P.H.N. render to nurses all over the country.

The institute plan is an excellent one for teaching groups of nurses. The A.S.H.A., following upon the work of Miss Moore and Miss Crain of the N.O.P.H.N., has continued to give institutes of a very practical sort to groups of nurses. By institutes we mean, of course, a series of lectures and demonstrations.

EDITED BY
DOROTHY J. CARTER

In Miss Carter's absence owing to illness, this department is being edited by the N.O.P.H.N. staff and the editor of the magazine.

A CITY SET ON A HILL

By C.-E. A. Winslow. New York: Doubleday, Doran & Company, 1934. 367 pp. $3.00.

In May, 1922, the Milbank Memorial Fund announced its intention of sponsoring and providing financial assistance for three health demonstrations in the State of New York—one to be in a rural county, one in a city of medium size, and the third in a metropolitan area. Syracuse was finally accepted as the location for the medium-sized city demonstration, and in 1923 the program was launched. At that time public health organization in Syracuse was well above the average among American cities. Its first real health organization was established in 1877 and the first medical health officer was appointed in 1884. As evidence of the effectiveness of the pioneer health work in this city, the fact may be mentioned that the last death from smallpox occurred in 1889. The school health service was instituted in 1905; a tuberculosis clinic was opened in 1908, and the county sanatorium began to take patients in 1916. In spite of these progressive steps in public health procedure there had been no full-time physician on the health department staff prior to the time of the demonstration. Among the immediate needs of the Syracuse health program were the development of a program for communicable disease control, a more definite campaign against tuberculosis, and the extension of health education. It was not until 1928 that a full-time health commissioner was appointed.

The author presents a historical review of the City of Syracuse from the time that it was constituted of only a group of huts, occupied by pioneers, on a lonely Indian trail. He pictures the gradual evolution of the health machinery of the community and paints a comparison of the health facilities at the beginning and at the termination of the demonstration period. The book is not only interesting to the public health worker because it affords a definite record of the progress of health work in Syracuse, but it portrays the standards of accomplishment in an average American community where modern health department procedure has been constructed with the aid of reasonable financial support. It gives us a rather clear picture of what the health officer can do with the aid of professional and lay groups in establishing and maintaining procedures which will guarantee definite results in the conservation of human life. Especially striking are the spectacular reductions in the death rates from such preventable diseases as diphtheria and typhoid fever. In the former case the average deaths per year have been reduced from an expectancy of 85 to a reality of but three; equally striking is the reduction in typhoid fever from an expectancy, based upon an experience of forty years ago, of 55 down to two. Of special note are the development of a municipal tuberculosis service and the establishment of a program of public health education. Every health officer will find this book not only entertaining but indispensable to his reference library.

HENRY F. VAUGHAN, M.D.

TRAINING IN PSYCHIATRIC SCHOOL WORK

By Sarah H. Swift. The Commonwealth Fund, New York City, $1.90

To workers interested in the training of students in the public health nursing field, the report of the Institute of Child Guidance of New York City on the

training of students in psychiatric social work may offer some thought-provoking facts.

When the Institute was established by the Commonwealth Fund in 1927 it listed its first function as a training center, and the development of the training program during the six-year period has received major consideration. The author gives a very well-defined outline of the development of the program, the problems related to it, and how they were met.

In summarizing the art of training, the author says that it lies not only in emphasis on the accumulation of knowledge and development of skill, but it is only through our own wish to grow and mature that we achieve the fundamental strength and perspective which may serve to stimulate in others the wish to develop a creative fulfillment in their own terms.

The longest chapter in the book is given over to a discussion of the supervisor-student relationship and methods used in the qualitative evaluation of the student's work.

CLARA B. RUE, R.N.

HUMAN PERSONALITY AND THE ENVIRONMENT

By Charles Macfie Campbell, M.D., Professor of Psychiatry, Harvard Medical School. The Macmillan Company, New York, 1934. $3.00.

From the point of view of creating a better understanding of those forces which control and modify human personality, Dr. Campbell's book carefully leads the reader to that end.

He discusses individual differences as they are affected by deprivations, such as oxygen, food, and water; by physical agents, such as sunshine and humidity; by the secretions of the endocrine and sex glands; by the senses and the central nervous system.

In chapter III, in which the development of personality from cell to persons is traced, the nurse will find familiar basic material with a new application. There the thought is developed that while those forces which determine man's ability to grasp his environment are determined early in the nucleus of the fertilized ovum, "he is the product of the interaction of" that "original system of forces with the cultural environment which surrounds and penetrates it."

In dealing with personality and some of the tasks of life, illustrations drawn from the lives of Helen Keller, Captain Scott, Theodore Roosevelt, and Bismarck show how handicaps, conflicts, and disturbances in personal equilibrium are met by compensations and adaptations according to the endowments and environmental advantages of each individual.

Dr. Campbell has stated that the material in the book is not new. Part of its value, then, lies in his new presentation of those principles and driving forces which control human personality.

Intended essentially for lay people, there would also seem to be a place for it in the reading of a graduate nurse—who, after all, is still a lay person in the field of psychiatry.

RACHEL C. COLBY, R.N.

PHYSICAL DEFECTS: THE PATHWAY TO CORRECTION

By American Child Health Association, New York City, 1934. 171 pp. $1.00 paper, $1.25 cloth.

This is the report of a study to determine why many school children, having the benefit of a school health service, continue to suffer from severe physical defects. The study was made by the American Child Health Association with the assistance of the Metropolitan Life Insurance Company, at the request of the New York City Departments of Health and Education. This report makes a valuable contribution to the literature pertaining to the health of school children.

The specific findings apply only to New York City, but in general they can be applied to any school system providing regular medical inspections as a part of its school health program. The study will be especially valuable to administrators and to the school nurses who have been disturbed and discouraged by the lack of desirable results from the medical examinations, for it

reveals many causes of failure. When these are known, steps can be taken to overcome them.

Efforts were concentrated chiefly upon four main items of the school health examinations, namely, vision, teeth, nutritional status, and hearing. Twenty-five thousand children in 121 schools were examined to find those with serious defects, and the findings were compared with the records on the health cards. Teachers, nurses, and parents were interviewed. The combined information provides answers to many disturbing questions.

The school procedure in correcting a defect is stated as follows: "For each condition there must be examination, the detection of the defect, the recording of the defect, the selection of cases for follow-up, the follow-up leading to appointment for professional attention, and, finally, to correction." The purpose of the study is to determine at what stage in the procedure—"the pathway to correction"—children with defects get lost. This is shown graphically for each of the defects studied.

The findings are summarized and general recommendations for overcoming the weaknesses in the follow-up are made as follows:

1. The available facilities both for follow-up and corrections should be considered in determining the defects for follow-up.
2. There should be accurate detection of defect cases with economy of effort.
3. There should be *rapport* among all the school health personnel.
4. Preparation for the home visit, sufficient to get results, should be made.
5. Essential records should be kept alive.

All these principles can be heartily endorsed with the exception of the first. It is the belief of this reviewer that the needs of the child should be considered in determining the severity of a selection for follow-up and not the available facilities for correction. A child with a defect may be benefitted by having the school and his parents know of the existence of the condition (even though a correction cannot be secured) because it will help them in understanding him. Furthermore, a teacher should be able to make some adjustments for the benefit of the child with poor vision or hearing if she knows a defect is present. Adequate facilities for all children will never be secured without great effort, and now, when thought is being given to ways for providing medical care for the general public, it seems the opportune time to work for measures for safeguarding the health of all children.

The report contains much information that will be helpful in studying any school health service and it is recommended to every one having any part in the service.

MARY EMMA SMITH, R.N.

New Careers for Youth. Today's Job Outlook for Men and Women from 17 to 32, by Walter B. Pitkin. Simon & Schuster, New York, May 1934, 236 pp. $1.50. A study of the need for a new attitude toward work, the importance of careful planning for a career, and suggestions for obtaining definite information about occupations and job hunting, written in Mr. Pitkin's interesting and understanding manner.

A unique weekly newspaper made its appearance on January 11th. It contains the news of the week in word and picture, edited by outstanding child authorities. The name of the paper is *The Boys' and Girls' Newspaper,* published by the Parents' Magazine Affiliated Press, Inc., New York, and will be devoted exclusively to subjects of interest to young people.

The less food money a family has, the more important is food planning—and as a guide to getting the most healthful food for the least money, *Good Food at Low Cost* has been prepared and published under the auspices of the Chester County (Pennsylvania) Medical Society. For those who don't know the important points in food buying, preparing, and planning, the tendency is to economize in the wrong places. *Good Food at Low Cost* tells you how your food money should be apportioned; how to make every penny count by judicious

buying; how to plan nutritious well-balanced meals; and also gives low-cost recipes and menus for three meals a day for four weeks. In these days of low incomes and rising food costs this is an excellent booklet for suggesting ways and means of giving the family the most strength and energy possible with the money spent for food. Twenty-five cents, postpaid, Chester County Medical Society, West Chester, Pennsylvania.

Statistics show that the common cold causes more than half of all absences from work and school—and the Life Conservation Service of the John Hancock Mutual Life Insurance Company (Boston) has issued a splendid little booklet, *That Mean Cold,* which gives the health rules for avoiding and treating this health and time robber. A boon to those who are "cold-haunted." Free *revised* pamphlet.

The American Social Hygiene Association, 50 West 50th Street, New York City, has issued a *revised* set of charts, *Social Hygiene and Family Case Work.* These charts were formerly called *Social Hygiene Exhibit for Nurses*—and are of particular interest to nurses, medical social workers, and others interested in family health and welfare. The charts sell for ten cents a set, eighty cents a dozen sets, and $5 per hundred sets, plus postage.

BOOKS AND PAMPHLETS ON HEART DISEASE

"Criteria for the Classification and Diagnosis of Heart Disease," *third edition,* by a committee appointed by the Heart Committee of the New York Tuberculosis and Health Association. This new edition presents the material in the original concise manner but the necessary changes have been made to bring the criteria up to date with the newer concepts in the classification and diagnosis of heart disease. Distributed by the American Heart Association, New York, $1.00.

Heart Disease Mortality Statistics, second edition, with statistics brought up to date. American Heart Association, New York, 25 cents.

Diseases of the Heart—This new booklet deals with the prevalence, causes, types, prevention, symptoms, and treatment of heart disease in articles written by leading doctors in this field. American Heart Association, New York, 25 cents.

The July-August-September 1934 issue of *The Commonhealth,* quarterly bulletin of the Massachusetts Department of Public Health, devoted to health education, is an unusually interesting number. The following articles are especially noteworthy:

Progressive Health Education
Ada Boone Coffey, R.N.
Health Education by the Community Health Association....Evangeline Morris
Health Education in a City Health Department .....Susan Murdock
Health Education Through Prenatal and Postnatal Letters and Other Printed Material.....Susan M. Coffin, M.D.
Art and Health Education
John H. McCarthy
Health Education in the Schools
John P. Sullivan, Ph.D.

FROM CURRENT PERIODICALS

A Study of Anorexia in Preschool Children. Amy L. Daniels and Gladys Everson. Journal of Home Economics, January, 1935. (Baltimore, Md.)

Concern of the United States with Tropical Diseases. F. W. O'Connor, M.R.C.S. American Journal of Public Health and The Nation's Health, January, 1935.

Active Immunization Against Poliomyelitis. Maurice Brodie, M.D. American Journal of Public Health and The Nation's Health. January, 1935.

Reduction of Maternal and Infant Mortality in Rural Areas. J. H. Mason Knox, Jr., Ph.D., M.D., F.A.P.H.A. American Journal of Public Health and The Nation's Health. January, 1935.

A Project in Rural School Health Education. Ruth E. Grout. IV. Relationships with Community Health Programs, from the Cattaraugus Supervisory School Hygiene District and the Division of Public Health Activities, Milbank Memorial Fund. January, 1935, Milbank Memorial Fund Quarterly.

Health Clubs as Applied to Dentistry. Charles Rider, D.D.S. Journal of the American Dental Association, February, 1935.

Nature—Builder of Teeth: A Dental Health Lecture. Journal of the American Dental Association, February, 1935. (See preceding note on this.)

● The preliminary announcement for the twenty-first annual observance of National Negro Health Week, March 31-April 7, has been issued by the U. S. Public Health Service. The announcement is in the form of an attractively multigraphed pamphlet of eight pages and contains helpful information such as application forms, program plan for organization, announcement and rules for the poster prize contest and application form, and suggested sources of coöperation. *The Family and Home as the Unit of Community Health* will be the Committee's special objective for 1935, as heralded by its slogan, "You cannot raise a healthy family in an unhealthy home." Two distinctive awards in the form of trophies have been designed for presentation to deserving groups. For further information write the National Negro Health Week Committee, U. S. Public Health Service, in Washington.

● Edna L. Foley, superintendent of the Chicago Visiting Nurse Association for the past twenty-two years, was awarded the first "citizen fellowship" membership, conferred by the Institute of Medicine of Chicago, at its recent annual meeting. The award was for helpful efforts to improve the civic, social, and health conditions of her city, especially through the Visiting Nurse Association.

● A new post has been created in nursing—that of nurse supervisor for the government of Newfoundland. Miss L. M. Whiteside has been appointed and is stationed at St. John's. Her task will be to improve the nursing service and to organize the maternity and child welfare centers.

● The Second International Congress on Mental Hygiene, which was to meet in 1935, will be held in Paris in July, 1936.

● The cost of monkeys has been one of the chief obstacles to the manufacture of the vaccine against infantile paralysis recently developed in the research laboratories of the New York City Health Department. One monkey produces vaccine for only ten immunizations. They are imported from India and cost from $7.50 to $8 apiece. However, contributions from large foundations announced recently will bring the cost down to $3.50 a monkey and reduce the cost of a single vaccination from $1.50 to 75 cents. The vaccine is now being made in sufficient quantity to permit weekly shipments to California to combat the epidemic there.

Tests made by the N. Y. Health Department show that nine out of eleven children inoculated are more immune after five months than at the beginning of the treatment. The other two had lost their immunity but when they were re-vaccinated, their immunity was restored in greater degree than before. So far, about five hundred children have been immunized in California and about one hundred children in New York. It is thought that two or three injections a year will confer complete immunity.

● The new officers of the Public Health Section of the Maine State Nurses' Association are: *Chairman,* Mrs. Louise Nichols, Dover-Foxcroft; *Vice-Chairman,* Mrs. Marion Oakes, Augusta; *Secretary-Treasurer,* Olive Bonsey, Millinocket.

● The twentieth annual meeting and dinner of the New England Industrial Nurses Association was held in Boston on January 12. Speakers were Dr. Donald V. Baker, Dr. James W. Seaman, and Dr. Luise Diez. Officers for 1935 include: *President,* Mrs. Helen J. Macrae, Builders Iron Foundry, Providence, R. I.; *Vice-President,* Carolyn Goyette, Universal Winding Company,

Providence; *Corresponding Secretary,* Catherine Dempsey, Cambridge, Mass.; *Treasurer,* Grace Van Buskirk, N. E. Laundries, Winchester, Mass. The Association now has 150 members and holds quarterly meetings in New England cities.

● The School of Nursing at Grasslands Hospital, Valhalla, Westchester County, N. Y., is offering a six months' course to graduate nurses interested in tuberculosis work. The set-up at Grasslands is modern, providing every phase of treatment of the tuberculous patient. There are 150 hours of class work given in theoretical and practical work.

● A report on motion pictures from the Office of Education, as printed in a previous issue of *School and Society* estimates that 70,000,000 persons attend motion picture performances every week in the United States. On an average, each child in areas where motion pictures are physically available goes to the movies once a week. Three out of four of the pictures that are shown relate to sex, crime or romantic love. The child retains two-thirds as much as the adult from his attendance at the movies.

Motion pictures change children's attitudes and these changes have a lasting influence. Motion picture appreciation courses in high schools offer a new and promising method for building better standards of judgment of films on the part of children. The Department of Commerce reports that 190,000 non-theatrical motion picture projectors are in use, including home sets. Thirty-two states have film libraries.

● As shown by the recent report of Annette Phelan, "A Study of School Health Standards," the need of evaluating health education programs was brought to light. Realizing this, the Illinois State Department of Public Health, Division of Child Hygiene and Public Health Nursing sponsored an Institute for School Nurses, November 16th and 17th at LaSalle, Illinois, Robina Kneebone, Supervisor of Health Education, Kansas City Public Schools, conducting. Sixty-four nurses attended, representing 20 counties. The program included the topics, "Changing Viewpoints," "School Health Education," "Rural School Nursing," "The School Nurse and the Community." Special emphasis was placed on "The Nurse as an 'Educator'," "Mental Hygiene in the School Health Program," "Changes in the Nursing Profession that Affect the School Health Program."

● Visitors from foreign shores who were welcomed at N.O.P.H.N. offices recently came from England, China, Czechoslovakia, Finland, Japan, Roumania, and Canada.

● Lillian M. Alexander, Director of Public Health Nursing, Atlanta (Ga.) City Health Department, and Thomas Hopkins Austin, Jr., were married in December.

● J. Beatrice Bowman has retired as superintendent of the U. S. Navy and Nurse Corps after more than twenty-five years of service in the Navy.

APPOINTMENTS

Helen Fenton, as county nurse in Bernadillo County, New Mexico.

Margaret Dizney, former American Red Cross nursing field representative, has been appointed Assistant to the National Director of Public Health Nursing and Home Hygiene, to succeed Helen W. Gould. Miss Gould goes to the New York Hospital School of Nursing as an instructor in public health nursing.

Opal Bundy, R.N., of the Indianapolis Public Health Nursing Association staff, has been employed by Kingan and Company, Indianapolis, as its new industrial nurse.

● Ada Newman has resigned her former position as State Supervisor of ERA nurses in Nebraska.

(For other appointments see page 163)

● "Have you a Shirley Temple dimple?" That is Iowa's way of talking about a vaccination against smallpox.